RESPONSE TO BISHCA QUESTIONS AND ANSWERS

Submitted October 16, 2006

RE: Docket # 06-013-H

Application for Conceptual Certificate of Need to create new inpatient programs to enhance psychiatric inpatient care and replace the functions currently performed by Vermont State Hospital filed on August 17, 2006, seeking a Certificate of Need (CON) to permit the Vermont Department of Health (VDH) to be authorized "to carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models" to replace the functions currently performed by Vermont State Hospital[1] and to permit VDH to "incur planning expenditures to analyze and compare the feasibility of various options for the replacement of the Vermont State Hospital".

Questions and Answers

1. **Please provide documentation and/or research supporting the statement that "The treatment of acute mental illness is increasingly integrated with medical and general inpatient services" (p.1)**

As noted in the November 20, 2003 Statement of Decision from Commissioner Crowley regarding the FAHC Material Change Application for the Renaissance Project and quoting testimony from POC testimony of Dr. Robert Pierattini,

"It appears to be the overwhelming opinion of the Mental Health Task Force that the medical and mental health treatment programs need to be co-located because they are so interdependent and so intertwined…Indeed, the medical director of the American Psychiatric Association reportedly has indicated his view, and in the opinion of the American Psychiatric Association, the integrated model of medical care of the kind proposed here is the current standard…."[1]

2. **Please provide documentation and/or research specifying what is required for treatment of acute mental illness to be considered "integrated with medical and general inpatient services" Does such integration require services to be provided:**
    a. **By the same entity?**
    b. **By the same staff?**
    c. **In the same building?**
    d. **On the same campus?**
    e. **Pursuant to the same policies and procedures?**

[1] Fletcher Allen Health Care Material Change Application for the Renaissance Project. Docket No. 03-006-H, Statement of Decision on Application for Certificate of Need, November 20, 2003, P.53.

f. **Using the same clinical standards?**

Please explain.

The following response addresses 2 (a) through (f)

The question of locating new inpatient psychiatric facilities in a location separate from inpatient medical services was settled during the public debate regarding the proposed project by FAHC to locate a new inpatient unit at the Fanny Allen Campus of FAHC. Among the chief objections to that project was the objection by consumers and providers to locating the unit away from the main campus.

"…opposition to this proposal developed in the community and among mental health professionals in large part because of the intended location of the service remote from other inpatient and diagnostic and treatment services. The remote location of the proposed unit from the main campus was considered a serious quality of care issue by interested parties to the application, physicians, and other members of the public…" [2]

Thus, the definition for clinical integration requires that psychiatric services be co-located within a primary medical center. See the response to Question 10 below. Clinical integration refers to the extent to which patient care services are coordinated across people, functions, activities and sites over time. This would include policies and procedures and clinical standards for same or similar settings. See the response to Question 16 below.

3. **Please specify what planning VDH will do, if it is granted a Conceptual CON, with which to meet its burden of proving, in the second (Phase II) CON application, that the "project will create new community mental health service capacities to reduce Vermont's reliance on involuntary inpatient psychiatric care."**

The planning to create new community capacities to reduce reliance on inpatient care has substantively begun, sufficient for Legislative appropriations. Throughout the next few years the following community capacities will be implemented (residential services at the sub-acute and secure levels of care, crisis stabilization beds, peer support services, housing, transportation and a system of care management).

4. **The application indicates it seeks authorization to "carry out feasibility analyses of multiple options and to develop detailed plans for the most feasible models." (p. 1.)**

    a. **What will such feasibility analyses consist of?**
    b. **How will VDH determine which, and how many, "multiple options" will be analyzed?**

[2] FAHC Material Change Application for the Renaissance Project, P.17.

c. **How does VDH define "feasible"?**
d. **Specifically with respect to financial feasibility,**
    i. **What is VDH's total budget, or budget range, available or reasonably anticipated to be available, for capital construction for the replacement of the services currently provided at VSH?**
    ii. **What is the total budget, or budget range, available or reasonably anticipated to be available, for operating expenses for the replacement of the services currently provided at VSH?**

Response to 4 (a) through (d):

The information provided in the August 17 Certificate of Need Application represents the most recent formulation of VDH's feasibility analysis. More complete analysis and planning will occur in Phase II.

5. **The application indicates VDH seeks permission to incur planning expenditures to analyze and compare the feasibility of "various options" (p. 2) for the replacement of the Vermont State Hospital but appears to reference only one option consisting of three components with possible variations of the construction plans within those components: construction of an inpatient psychiatric facility on the Burlington campus of Fletcher Allen Health Care (FAHC), renovation and expansion of the inpatient psychiatric facility on the campus of Rutland Regional Medical Center (RRMC), and some undefined expansion on the campus of Retreat Healthcare (Retreat).**

    a. **Is this the extent of the "various options" VDH intends to incur planning expenditures to analyze?**

The Conceptual CON application requests permission to incur planning expenditures to develop two new levels of inpatient psychiatric care:

Under the license of Fletcher Allen Health Care (FAHC) to develop programming at the specialized and intensive levels of care:

1. Create a 40-bed stand alone psychiatric hospital on or off the Burlington campus, or
2. Create a 40-bed program that is physically integrated with FAHC's existing inpatient services, or
3. Create a 68-bed program combining FAHC's current 28-bed program with 40 new beds physically integrated with the inpatient services

and

Under the License of Rutland Regional Medical Center (RRMC):

4. Establish 6 new psychiatric inpatient beds at the specialized level of care with the current program at Rutland Regional Medical Center via renovations and/or new construction to optimize current inpatient programming and bed capacity.

and

Under the license of Retreat Healthcare:

5. Establish the capability to provide up to 6 psychiatric inpatient beds at the specialized level of care at the Retreat Healthcare.

b. **If so, what would VDH do if all or part of this plan proves not to be feasible?**

If developing new capacities at Rutland Regional Medical Center or the Retreat Healthcare does not prove feasible, the number of beds planned for the primary program with FAHC could be increased. In addition, through the Phase II process, other options may become apparent.

c. **If not, how will VDH determine what other options to explore as part of its analyses?**

The CON Application of August 17, 2006 describes the preferred option resulting from planning processes conducted to date. Preliminary work suggests that for programmatic, policy and fiscal reasons (as described in the August 17 Application) the preferred option reflects the optimal solution available to balance objectives of improved service quality, patient access and long-term cost effectiveness of the system. The Department will explore other options that might emerge during the detailed planning processes in Phase II.

6. **The application indicates the preferred options would be "under the license" of FAHC, RRMC and the Retreat.**

a. Under what entity's license are the current services provided?

Current inpatient services at FAHC, RRMC and the Retreat are provided under the hospital license of each corresponding entity.

b. Why are the services currently provided under such license and by what authority?

The services are currently provided under each entity's license pursuant to the statutory and regulatory requirements of 18 VSA Chapter 43 *Licensing of Hospitals* and Vt. Code R. 13 140 019 *Hospital Licensing Procedure.*

c. Why does VDH plan to have the replacement programs provided under the licenses of FAHC, RRMC and the Retreat?

Under the preferred option, psychiatric services would be integrated with general medical services and, for limited use, integrated with an existing specialty psychiatric inpatient provider and thus subject to the licensure requirements of the providing hospital.

d. Could the replacement programs be provided under the same license as the current VSH without negative financial or programmatic impact? Explain

VSH services are regulated by the Division of Mental Health pursuant to statutory authority granted in 17 V.S.A. §7205. The current VSH program is specific to the Waterbury facility. The replacement programs will be provided on the site of the partner hospitals. Therefore it is not possible that the replacement programs could be provided under a VSH hospital license. We are not aware of any legal or regulatory scheme that anticipates such a hospital license in Vermont.

7. **The Civil Rights of Institutionalized Persons Act[2] (CRIPA) protects against deprivations of rights, privileges or immunities of persons residing in or confined to an institution which is "owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State" and which is "for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped;…" It permits initiation of civil actions by the Attorney General whenever he or she has reasonable cause to believe that "any State or political subdivision of a State, official, employee, or agent thereof, or other person acting on behalf of a State or political subdivision of a State is subjecting persons residing in or confined to an institution" to deprivation of rights.**

    a. **Would patients served by the replacement facilities proposed by VDH be protected by CRIPA even if those facilities are operated under the licenses of private entities? Please explain.**

No. If the programs are deemed privately owned and operated and do not meet the definitions of "institutions" under CRIPA, then the facility will not be under the jurisdiction of CRIPA.

8. **The application indicates the "preferred options" include creating "a 40 bed stand alone psychiatric hospital on or off the Burlington campus" of FAHC (p. 2), 6 new psychiatric inpatient beds at RRMC, and up to four psychiatric inpatient beds at the Retreat.**

    a. **This appears to differ somewhat from BISHCA's previous understanding of the number of beds VSH plans to locate at FAHC and what the preferred location at FAHC is. Please explain.**

The preferred option is to develop a 68-bed program on the main campus of Fletcher Allen with physical connection to the inpatient care services. This would include FAHC's current psychiatric inpatient service. If this is not feasible to develop, we will explore developing a 40 bed capacity on or off the Burlington campus.

The number of beds planned for the new inpatient programs has evolved based on the actuarial findings, from 32 to a total of 50 beds. Refer to Appendix B of the August 17, 2006 CON Application. Of these, we seek permission to plan for the feasibility of 40 additional beds on or off the FAHC Burlington Campus.

b. **Explain the methodology used to determine that 6 beds are the appropriate number to add at RRMC.**

The methodology for determining the number of beds needed is described in the Milliman report (August 17, 2006 CON Application, Appendix B). This actuarial study relied on historical population experience and anticipated environmental changes during the projection period. The methodology also considered varying degrees of complimentary community resource planning and implementation which will impact the actual bed need in the future, but which is not possible to determine with absolute accuracy at this time, because these resources will be implemented in accordance with Department planning and legislative appropriation of necessary funding.

RRMC, through their RFI response, indicated interest in developing up to eight new beds. The preliminary architectural work to assess the feasibility of renovating within the existing floor plan yielded a design for 6 new beds.

The Advisory Committee recommendations were to develop the preponderance of beds at a single location, with one or two smaller capacities for geographic accessibility.

c. **Explain the methodology used to determine that up to 4 beds are the appropriate number to add at the Retreat.**

See response to (b) above

9. **The application indicates that if new capacities at RRMC and the Retreat prove not to be feasible the number of beds planned for the primary program with FAHC could be increased.**
    a. **Provide all information VDH is aware of that indicates limitations on how many beds FAHC can accommodate on the Burlington campus and/or on any other campus.**
    b. **Specifically, what are the limits to the numbers of such beds that can be added at FAHC's campuses?**
    c. **If adding any or all new capacities at FAHC prove not to be feasible what would VDH do to meet the need?**

The following response applies to (a), (b), and (c):

The proposed options in this planning CON application are not specific enough at this time for FAHC to respond to these questions. There are numerous factors that would affect the number, placement, and configuration of inpatient psychiatric beds on its campus, including programmatic needs and goals, hospital licensure, the criteria in the CON program, FAHCs future needs and plans for its campuses, the availability of adequate funding, zoning, planning and land-use restrictions, agreements with the City of Burlington affecting the FAHC campus and adjacent neighborhoods, adequacy of community social services to support psychiatric patients upon discharge, traffic considerations, and infrastructure limitations, including food and utility facilities.

In the event that further analysis in Phase II planning suggests the need to develop additional enhanced bed capacity, the Department will explore other available options.

10. **The application references advantages of providing psychiatric care at a tertiary level hospital (see p. 3 for example). Please specify these advantages and indicate how they directly relate to specific deficiencies at VSH.**

The literature states that "Adults with mental illnesses have higher rates of chronic general medical conditions (than the general medical population), including hypertension, HIV/AIDS, and diabetes, a higher frequency of multiple general medical conditions, and a higher rate of premature mortality resulting from these conditions."[3] Additionally, a myriad of physical health conditions can present with symptomology of mental illnesses (for example, cancer, thyroid disease, side-effects of medications, Parkinson's disease, all may be incorrectly diagnosed as depression). The general medical conditions of psychiatric patients are "frequently missed."[4] Because of the severity of the mental illnesses of the patients who would occupy the VSH inpatient replacement beds, the advantages of physical co-location include provision of standard medical / surgical services (such as labs, pharmacy, IV therapy, diagnostic radiology and anesthesia, etc.) resulting in routine screening for and easy access to treatment of physical health conditions. "Having psychiatric services co-located in a primary medical center ensures an environment that keeps at the forefront immediate access to the highest quality of medical and psychiatric care in a single setting."[5] Such services are not available on-site

[3] J. Sokal, , et al (2004). "Comorbidity of Medical Illnesses among Adults with Serious Mental Illness Who Are Receiving Community Psychiatric Services," Journal of Nervous and Mental Disease 192, no.6: 421-427, cited in M. Horvitz-Lennon, A. M. Kilbourne and H.A. Pincus, (2006). B. Felker, J. Yazel & D. Short (1996). "Mortality and Medical Comorbidity Among Psychiatric Patients: A Review, Psychiatric Services 47: 1356-1363; C. Carney, L. Jones, R. Woolson (Nov 2006). "Medical Comorbidity in Women and Men with Schizophrenia: A Population-Based Controlled Study," Journal of General Internal Medicine 21: 1133; (**Attachment 1**). "From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses," Health Affairs (May/June) 25, 3: 659-669 (**Attachment 2**).

[4] Horvitz-Lennon, Kilbourne & Pincus, p 660.

[5] Steve Bartells, MD, Associate Professor of Psychiatry, Dartmouth College. Testimony presented before the Public Oversight Commission, Fletcher Allen Health Care CON Application, May 2002 (**Attachment 3**). Also, Phil Mushkin, MD, Professor of Clinical Psychiatry, Columbia University, testimony presented before the Public Oversight Commission, Fletcher Allen Health Care CON Application, May 2002 (**Attachment 4**).

at VSH. The stand-alone structure itself constitutes a barrier to the provision of recognized standards for best practice of care.

11. **RRMC and the Retreat are not tertiary level hospitals. Given your response to question 10 above, why would it be appropriate to provide care to some portion of the population served by VSH at FAHC but provide care to the rest of the population at less than tertiary level facilities?**

This plan seeks to provide appropriate care to all patients in the appropriate setting according to clinical need. Not all inpatient psychiatric patients require full tertiary care hospital services. The design presented in the CON Application is that of a state-wide system with the capability of placing and transferring patients among the hospitals according to clinical need. FAHC is considered the tertiary care facility for the state. Patients requiring tertiary care services would be placed at FAHC. Those primarily requiring psychiatric treatment would be placed at RRMC and the Retreat. Patients requiring community level inpatient medical and mental health services will be served in the nearest appropriate community hospital. FAHC and RRMC are also community hospitals serving their local geographic area

12. **Page three of the application specifies core policy considerations driving the concept of replacing VSH. These include "integration of psychiatric inpatient care with general inpatient care", co-locating "all of Vermont's tertiary-level psychiatric inpatient care with Vermont's only tertiary hospital" and developing "new community capacities" to reduce Vermont's reliance on inpatient care…"**

a. **How does VDH define the integration of psychiatric inpatient care with general inpatient care?**

Close physical proximity to allow for rapid and appropriate access to hospital inpatient diagnostic and treatment services.

i. **How does VDH expect this could be accomplished on the Burlington campus of FAHC?**

The preferred option is to be physically connected to the inpatient care, for example the McClure building. This would facilitate integration with other tertiary-level inpatient medical care.

ii. **How does VDH expect this could be accomplished on any other FAHC campus?**

It would be impossible to accomplish the preferred option of integration with tertiary-level care on any other FAHC campus.

iii. **How does VDH expect this could be accomplished on the RRMC campus?**

The preferred option is to renovate existing space in the RRMC allowing for integration with community hospital level care.

iv. **How does VDH expect this could be accomplished on the Retreat's campus?**

It is not possible to accomplish integration with community or tertiary-level care on the Retreat campus.

b. **Please define tertiary level psychiatric inpatient care. How does that term relate to the application's use of the following categories (please note these terms were derived from reviewing the application and are worded in such a way as to hopefully best capture the nomenclature used by VDH. They are intended to be descriptive, informative and inclusive rather than exclusive. If, for example, VDH does not define crisis diversion beds as "mental health crisis diversion beds" please respond as best possible. If it is necessary to make distinctions between such terms please do so and explain):**
   i. **Intensive care psychiatric beds/units**
   ii. **Specialized inpatient psychiatric beds/units**

Tertiary care as defined in the HRAP is "Specialized consultative care, usually on referral from either primary or secondary care personnel, by specialists working in a center that has the personnel and facilities for special investigation and treatment of highly complex cases." Tertiary-level psychiatric inpatient care is accomplished in the same manner and defined in this application as Intensive and Specialized inpatient care.

iii. **General hospital psychiatric beds/units**

The term general hospital psychiatric beds/units refers to the community hospital level of care as opposed to tertiary level.

iv. **Mental health crisis beds/units**
v. **Mental health crisis diversion/triage beds/units**

Items iv and v refer to the same level of care. See Question 72a for definitions.

vi. **Secure residential beds/facility**

Secure residential treatment programs will be designed to meet the needs of individuals whose symptoms are sufficiently stable to no longer need inpatient care, but who are legally restricted from discharge from a secure setting.

vii. **Sub-acute beds/facility**

The **residential recovery programs at the sub-acute level of care** are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals often have a slow response to treatment and multiple disabling conditions. With individually focused rehabilitation programming in non-institutional settings, this population is believed to be capable of making significant gains towards recovery. The current VSH environment, while very caring and supportive, is fundamentally institutional. As such, it constitutes a very difficult environment for engagement in the building of adequate recovery skills to successfully maintain recovery in a less-structured setting.

c. **How will VDH use planning authorization granted in a conceptual CON to develop, define, and describe the "new community capacities" that would be implemented as part of the plan?**

The Futures planning process, as legislatively set forth, requires planning for new inpatient services within the context of a comprehensive continuum of care. As such it envisions the program elements described in the Futures plan (residential, peer support, transportation, housing, and crisis beds specifically). Various work groups of the Advisory committee combined with the management of VDH and the community providers will continue the development work on these community capacities.

13. **The application indicates that "all of Vermont's hospitals" were invited to an information session on August 31, 2004. Dartmouth Hitchcock Medical Center (DHMC) is a tertiary level academic medical center serving significant portions of Vermont and which derives significant revenues from Vermont. It also has an inpatient psychiatric program and engages in many collaborations, joint ventures, and alliances with several Vermont hospitals and other health care providers.**

a. Was DHMC invited to the referenced information session or any similar initiative?

Because DHMC is not located in Vermont, it was not invited to participate. However, Vermont hospitals that are affiliated with DMHC were invited to participate.

b. If so, what was the result?

NA

c. **If not, why not?**

In order for an out of state hospital to be a feasible inpatient partner, the hospital would need to be willing and able to accept both voluntary and involuntary admissions. While DHMC might be willing and able to accept involuntary patients from Vermont, barriers exist to such a scenario. A considerable proportion (approximately 60% of the average daily census) of VSH patients are hospitalized temporarily while they are awaiting either a court ordered forensic evaluation, an initial civil commitment hearing, or an Act 114 hearing. Attempting to utilize DMHC for these patients would require regular transportation of these patients back and forth to Vermont for access to legal counsel and judicial proceedings, and possibly to access their independent psychiatrist before each hearing. Additionally, it is not clear whether involuntary treatment, consistent with the protections of Act 114, could be initiated or implemented in New Hampshire.

14. **Please provide documentation of all initiatives to invite hospitals to participate in providing services as part of a plan to replace VSH. Please include all letters, agendas, reports, and other documentation reflecting the VDH's efforts in this regard and the responses by the hospitals.**

Attached is the letter of invitation to participate in the August 31, 2004 informational session. Attachment 5) The copy attached was sent to Brattleboro Memorial Hospital. All Vermont hospitals received this invitation. (This is the extent of the documentation we can provide; we cannot locate copies to each hospital due to the relocation of the Division's offices to Burlington in early September 2005).

Also attached is the sign-in sheet for this meeting.(Attachment 6)

The next formal solicitation was through the December 2004 Request for Information (RFI). The RFI and responses was included in the conceptual CON application of August 17, 2006.

15. **The application indicates (see, e.g. p. 4) that the Retreat is an Institution for Mental Disease (IMD). The application also notes the importance of partnering with institutions, when replacing VSH, in such a way as to ensure the VSH replacement programs do not prevent the receipt of federal funds due to the IMD exclusion.**
    a. **Will the services provided by the Retreat as part of the plan proposed by VDH be entitled to federal funding or will such services be barred from federal participation because of the Retreat's status as an IMD?**

Generally, services provided by the Retreat are barred from federal financial participation because of the Retreat's status as an IMD. However, during the term of Vermont's current Global Commitment 1115 waiver (set to expire on September 30, 2010), the state can receive federal matching funds for state plan psychiatric inpatient services provided to Medicaid eligible patients being treated at a certified provider. However, it is important to note that the 1115 waiver is scheduled to expire and be renewed in four years (September 30, 2010) and it is uncertain, based on the experience in Vermont and

in other states, whether CMS will continue to allow Medicaid payments to an IMD through the 1115 waiver process in the future.

Attached is communication from HCFA re: rescission of Vermont's previous waiver of the IMD exclusion (Attachment 7).

b. If such services to be provided at the Retreat would not permit federal funding why does VDH propose partnering with the Retreat?

The Retreat has a high level of interest in partnering with the State. As a specialty psychiatric inpatient provider, it offers services valued by the VDH. In addition, the physical location of the Retreat facilitates geographic access to specialty psychiatric care for Southeastern Vermont.

c. If such services can be provided at the Retreat in a manner to enable federal funding despite the Retreat's IMD status, why is this? And, if so, could such a process to receive federal funds at an IMD apply to other IMD's now existing or that might be created within the State?

Aside from the time-limited availability of funds under Vermont's current Global Commitment Plan, we are not aware of any manner by which the Retreat or any other existing or to be created IMD can provide VSH replacement services that would enable federal funding.

d. Please explain and document any and all communications VDH has had with the Centers for Medicare and Medicaid Services, or any other appropriate or relevant entity, regarding the IMD funding issue.

VDH has not had direct communications with CMS regarding the Global Commitment Agreement and IMD.

e. At the June 20, 2006 Mental Health Oversight Committee hearing VDH indicated there might be ways to obtain federal participation for the beds at the Retreat despite its IMD status. Please explain.

See the answer to (a) above.

16. **Does, and if so, why does, VDH continue to support the recommendation referenced on page 5 that "an in-patient facility of up to twenty-eight (28) beds, including eight (8) psychiatric intensive care unit (ICU) beds" should be (recognizing the numbers may have since been adjusted based on further information):**

    a. **co-located with a general hospital**

VDH continues to support co-location of psychiatric services within at least one tertiary care hospital and at least one other community hospitals to advance quality of and access to integrated psychiatric and physical health services for Vermonters with severe mental illnesses. Co-location helps facilitate integration of care through close physical proximity to allow for rapid and appropriate access to hospital inpatient diagnostic and treatment services. (Attachment 8)

b. **managed by a general hospital**

Clinical integration is defined as "the extent to which patient care services are coordinated across people, functions, activities and sites over time."[6] Current models of best practice to achieve clinical integration recommend that management of psychiatric and other medical conditions be organizationally integrated.[7] Accordingly, to achieve clinical integration and thus enhanced service quality, VDH believes that reformed inpatient mental health system services are best managed by a general hospital. (Attachment 9)

c. **governed by a general hospital**

The goal of the Futures plan is to achieve clinical integration of psychical and mental health services for inpatient care. To the extent that governance involves institutional oversight of the delivery of clinical services, the role of the general hospital is to maximize positive patient outcomes of care through integration of physical and mental health services. In performing these duties, the hospital would continue to be accountable to its governing and accrediting bodies for all services it provides to all patients it treats. At the same time, the Division of Mental Health (and now the Commissioner of Health) has statutory authority and responsibility for oversight of services provided to persons with severe and persistent mental illnesses. (See CON Application p 10 for specific statutory citations.) The role of VDH and the Division of Mental Health in a reformed system would be to provide quality and contractual oversight of services managed by the general hospital. Specification of the details of governance would be developed in Phase II planning processes.(Attachment 10)

17. **The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options are represented on pages 5-6 as calling for a primary site and one or two smaller inpatient capacities created**

[6] Stephen Shortell cited in Horvitz-Lennon, Kilbourne and Pincus p.661.(Attachment 2)

[7] S.M. Shortell et al. (2000). Remaking Health Care in America: The Evolution of Organized Delivery Systems, 2d ed. San Francisco: Jossey-Bass, 129-186. K. Minkoff (2001). "Program Components of a Comprehensive Integrated Care System for Seriously Mentally Ill Patients with Substance Disorders," New Directions in Mental Health Services, 91: 17-30. R.W. Schaedle & I.Epstein (2000). "Specifying Intensive Case Management: A Multiple Perspective Approach," Mental Health Services Research 2,2:95-105. Institute of Medicine (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions. Washington: National Academies Press.(Attachments 8, 9, 10) President's New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America. Online: http://www.mentalhealthcommission.gov/reports/reports.htm

for "geographic accessibility with close coordination, clinical collaboration, and common standards for consistency."

a. **How is geographic accessibility defined?**

The inpatient work group did not specifically define geographic accessibility. Geographic accessibility would be defined by HRAP and Certificate of Need Standards. HRAP defines geographic accessibility as the distance patients need to travel for services. It recommends review and update for most access standards. Until there is further update, the HRAP recommends a standard of 60 minutes for some tertiary care services. This plan improves geographic access to Vermonters in need of inpatient psychiatric services.

b. **How is close coordination defined?**

Coordination includes the rapid and appropriate ability to share information, provide case consultation across clinical disciplines using common clinical standards and protocols. The care management system envisioned in this plan will provide the infrastructure for close coordination. Models for defining close coordination, clinical collaboration and embodying common standards for consistency are under development. It is expected that final products would emerge in the Phase II planning processes.

c. **How is clinical collaboration defined?**

Clinical collaboration is the interaction and communication across disciplines that allows for appropriate diagnosis and management of illness in accordance with best practice. See (b) above.

d. **What is meant by "common standards for consistency"?**

See (b) above. In this CON application, "common standards for consistency" refers to standards that are implemented across the system of care so that all Vermonters receive the same level of care no matter where the location of care may be. These standards will be developed in the planning process and will be consistent with the IOM goals for care and with best practice.

The clinical standards and protocols intended in the recommendation of the Futures Project Inpatient Work Group include but are not limited to:

- Common admission, continued stay and discharge criteria.
- Common program elements and treatment protocols
- Common clinical operating procedures including treatment planning.

e. **Does VDH now have a plan to achieve such accessibility, coordination, collaboration and standards?**
   i. **If so, please explain**

The Futures Project Care Management work group is charged to guide the development of such a process.

ii. **If not, please indicate how a conceptual CON would be used to develop such a plan**

As noted in the questions above, accessibility, coordination, collaboration and consistency standards are concepts that will be further developed in Phase II planning.

18. **The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options as represented on pages 5-6 indicate the primary VSH replacement facility should not be an IMD.**
    a. **Does this mean it would be acceptable for the secondary sites to be IMDs? Why or why not?**

It would be preferable for all replacement facilities be eligible for federal financial participation. However, in the event that is not feasible, it would be *acceptable* for one or more secondary sites to be IMDs.

19. **The recommendations of the VSH Futures Advisory Committee work group on the inpatient setting and partner options as represented on pages 5-6 indicate the primary VSH replacement site must be a designated hospital. Subsequently, VDH determined the secondary VSH replacement sites must also be designated hospitals. Why?**

The severity of illness of the patients occupying VSH replacement beds require the knowledge, skill set and staff available in hospitals with defined psychiatric units.

20. **Pages 6 and 7 of the application list criteria developed by the above-referenced work group.**
    a. **Are these a verbatim reproduction of the criteria as set forth by the work group? If not please explain.**

Yes, the list of criteria in the application are a verbatim reproduction of the criteria as set forth by the inpatient work group.

b. **How does/will VDH weigh these criteria when analyzing or investigating possible partners?**

These criteria will be used in planning activities under Phase II. It is expected that refinement such as assignment of relative weights, should this be deemed advisable, will occur at that time.

c. **How does/will VDH weigh these criteria when analyzing or investigating possible sites?**

These are general, qualitative criteria that must be balanced in considering any and all potential sites. Their application is intended to stimulate planning consideration of all relevant dimensions to be addressed in reconfiguring mental health in-patient care. If there is need to attempt to refine them further, this will occur in Phase II.

d. **Please provide a matrix indicating how each of the three partners identified to date, FAHC, RRMC and the Retreat, meet each of the prescribed criteria.**

We have described the full extent of planning outcomes available from the Phase I process in the August 17 CON Application. In order that application of the criteria can adequately represent the views of the various parties involved, VDH respectfully submits that further application of the criteria should await the Phase II planning process.

21. **Please explain, with respect to the statement on page 7 regarding Springfield Hospital's status as a Critical Access Hospital (CAH), whether VDH is aware of any method, such as alternate licensing, by which inpatient psychiatric beds could be added to either the Springfield or Bellows Falls campuses (or a new campus) of Springfield Hospital in compliance with the CAH rules and/or in such a way as to permit federal financial participation despite the IMD rules. Please explain.**

We are not aware of any method by which inpatient psychiatric beds could be added to either Springfield or Bellows Falls campuses (or a new campus) of Springfield Hospital in such a way as to permit federal financial participation despite the IMD rules.

22. **Regarding the discussion on page 8 regarding funding for VSH and for the community agencies, please explain:**
    a. **The sources of such funding**

See the table below for historical funding information.

Community Agencies

Funding Source	SFY 2004	SFY 2005	SFY 2006
1st/3rd Party	$14,844,895	$11,851,464	$12,912,815
CRT Case Rate	$27,554,828	$28,813,165	$30,735,244
DMH/Grants	$5,599,783	$7,081,550	$7,247,641
Federal Grants	$2,015,764	$1,922,328	$1,492,890
ICF/MR	$961,508	$1,010,063	$979,593
Local/Other	$8,924,652	$9,790,195	$10,478,344
Medicaid	$42,808,457	$45,984,652	$48,792,156
Other State	$15,024,276	$20,552,729	$21,083,711
PC Plus	$3,010,237	$5,211,467	$5,552,391
Waiver/PNMI	$73,724,679	$77,908,178	$81,808,937
TOTAL	$194,469,079	$210,125,791	$221,083,722

Vermont State Hospital

Funding Source	SFY 2004	SFY 2005	SFY 2006
Medicaid	$4,589,070	$3,063,860	$14
Medicare	$294,043	$429,863	$0
Canteen	$155,140	$175,618	$225,182
Interdepartment Transfer (MH/HD)	$300,000	$0	$450,022
GF	$8,182,352	$11,363,407	$16,596,319
	$13,520,605	$15,032,748	$17,271,537

b. **The extent to which such funding is a "zero sum game" with increased resources for one coming at the expense of the other**

The funding is not a zero sum game between VSH and the community agencies. Funding has increased significantly over the last three years. From SFY 2004 to SFY 2006, funding has increased by $3.75 million for VSH and by $26.6 million for the community agencies.

c. **Perceived opportunities for or limitations on funding for both programs in the foreseeable future**

Any perceived opportunities for or limitations on funding will be addressed in the second Designated Agency sustainability study. The contract for this is to be let in January 2007 and is planned to be completed in August 2007 for the SFY 2009 consideration. (See question 37 for reference to this planned study.)

23. **What is the likelihood that the past negative financial pressures on VSH, described on page 10, would continue or re-occur in the future? Please explain.**

Due to increased costs for healthcare and new caseload pressures across the Agency of Human Services (AHS), VSH will face financial pressures in the future. However, AHS and the Administration will address these negative financial pressures through the state budgeting process.

24. **Vermont's 14 not-for-profit community hospitals subsidize many of their programs that do not cover costs through revenues from other programs that cover costs and earn a margin. Furthermore, these hospitals cost shift from low reimbursing payers (generally, payers who pay less than cost) to higher reimbursing payers (who generally pay more than cost), usually commercial insurers. If replacement facilities for VSH are co-located on, managed by, and governed by some of these community hospitals:**
    a. **What is the risk that costs to cover the VSH replacement inpatient psychiatric programs will be subsidized by other hospital programs? Please explain your analysis.**

Analysis has not been conducted on the risk of VSH replacement inpatient psychiatric programs being subsidized by other hospital programs.

    b. **What is the risk that costs to cover the VSH replacement inpatient psychiatric programs will be shifted to other payers such as commercial insurers? Please explain your analysis.**

VSH's inpatient partners have clearly stated that costs for new psychiatric services cannot be handled by other existing programs.

25. **The applicant proposes to make substantial capital improvements, using public funds, to the campuses of private institutions.**
    a. **What entity(ies) will own the resulting facilities?**

What entities will own the VSH replacement facilities requires further research and negotiation.

    b. **What entity(ies) will control the use of the resulting facilities?**

What entities will control the use of the VSH replacement facilities depends on the answer to (a) above and requires further research and negotiation.

    c. **What rights will VDH have to require continued use of the resulting facilities for the VSH replacement programs?**

The rights that VDH will have to require continued use of the resulting facilities for VSH replacement programs is dependent on ownership/management decisions which require further research and negotiation.

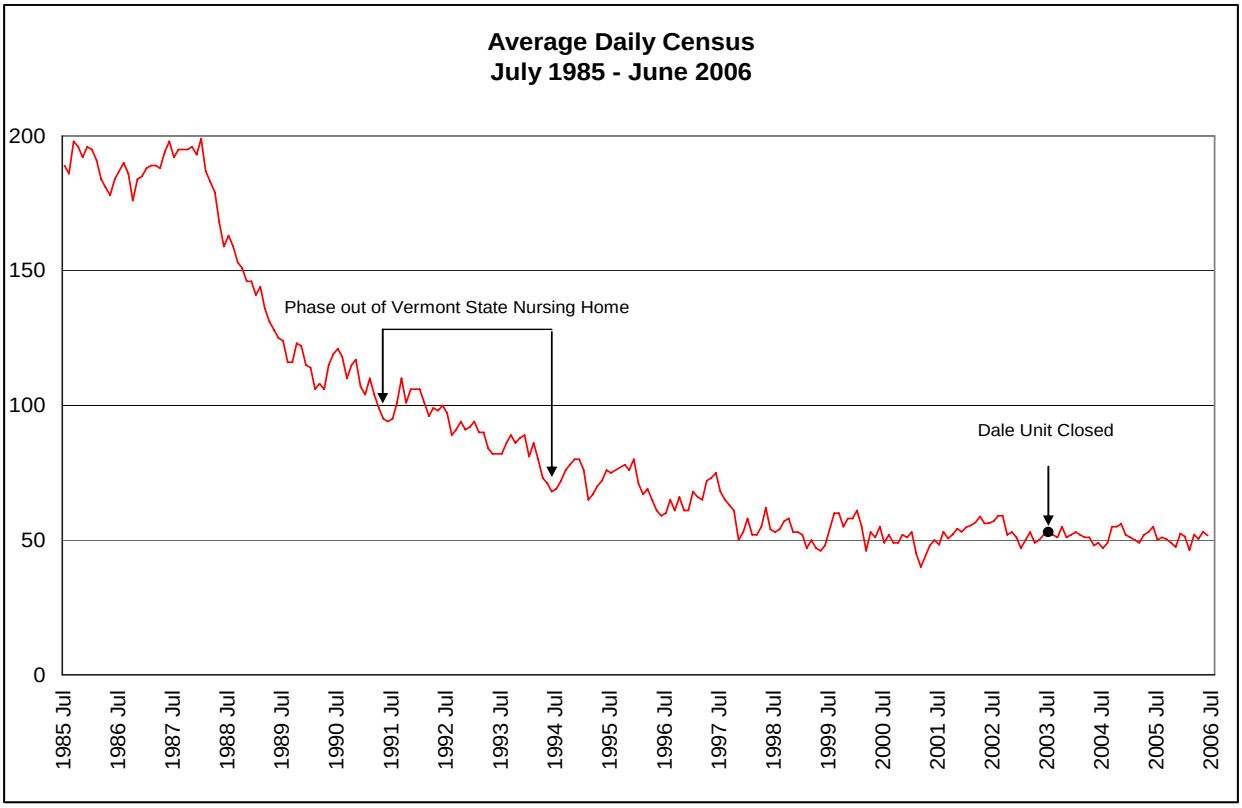
26. **Vermont's CON laws do not require that an entity, such as a hospital, obtain a CON before the discontinuance of a health care service. For example, FAHC would not need to obtain a CON to discontinue providing inpatient psychiatric services. The State's obligation to provide the inpatient psychiatric services described in the application is perpetual, however.**
    a. **Please explain how VDH will ensure the partners will continue to provide the needed services.**

VDH is exploring options that will ensure that the partners will continue to provide the same level of services that are legally required, maintain a no-reject policy, and serve all of the populations currently served.

    b. **Please explain how VDH will ensure the partners will continue to provide the needed services in the prescribed locations and according to the State's standards and needs.**

VDH is exploring options that will ensure that the partners will continue to provide the needed services in the prescribed locations.
VDH currently uses the Designated Hospital program to ensure that partner hospitals serve patients according to the State's standards and needs. Please refer to Question 115 for more detail on the Designated Hospital program.

27. **Please explain the history of the Dale Unit at VSH and provide census data pre- and post-closing of the Dale unit to illustrate the impact on VSH's census. Please explain how VDH provided for the needs of the patients no longer served on that unit.**



Plans to transfer the functions of the Dale Unit of VSH to the community were developed throughout 1995 and 1996 with key service provider, consumer, and family stakeholders. The plan called for the development of new crisis bed and residential services. In addition, individual patient "wrap-around" placements were designed. As the plan was being implemented, additional resources for intensive outreach supports were also developed. Refer to the Table above, "Average Daily Census, July 1985 – June 2006."

28. **One of the advantages of providing inpatient psychiatric services in partnership with the state's community hospitals appears to be an ability to provide more appropriate and timely physical health care.**

    a. **Please explain how this is provided currently to patients at VSH**

A full time physician combined with the nursing staff provides on-site medical services. When diagnostic or treatment services beyond the current capacity are required, the patient is transported to physician offices for outpatient services or to the nearest appropriate hospital.

b. **How is it paid for?**

The in-house services are counted as an expense in the overall VSH budget which is currently supported primarily by State General Funds. When a patient is transported for medical care off-site, the patient's insurance is billed.

c. **Please explain how it would be provided under the new model**

Under an integrated model, the care would be provided in a more timely and comprehensive fashion. Locating inpatient psychiatric beds within the hospital setting provides the ability for ready access to medical providers, including specialty providers. This location will facilitate early evaluation and treatment and in most cases will eliminate the need for complex transport. In the event that transport is needed from a community level to a tertiary level for medical evaluation, the transport will be more timely with the likelihood that the patient is medically more stable than is currently possible at VSH.

d. **How would it be paid for?**

The care would be reimbursed through established rate setting mechanisms. It is anticipated that Medicaid or the patient's primary insurer would be the source of funds.

29. **Generally, tertiary hospitals, especially academic medical centers, have higher fixed costs than other hospitals**.

a. **Has VDH examined this issue with respect to the physical health care that psychiatric in-patients would receive at FAHC?**

No

b. **Has VDH examined this issue with respect to the mental health care that psychiatric in-patients would receive at FAHC?**

No

c. **If so, what has VDH projected to be the nature of the resulting cost differential?**

N/A

d. **If not, how does VDH plan to discern and weight this in planning for the Phase II CON?**

This will be examined in Phase II planning.

30. **Please present a proposed budget for expenses VDH anticipates incurring in preparation for filing the Phase II CON application, indicating expenditures by category.**

We do not have a proposed budget at this time for preparing a Phase II CON application. This will be developed in the planning process prior to preparing a Phase II CON application.

Near term planning milestones in order to assess the feasibility of the options presented in the application for a Planning CON include, but are not limited to the following.

- Development of the program model for Intensive and Specialized levels of care.
- Outside review of the program model for consistency with accreditation standards, appropriateness for the population to be served, and cost-effectiveness.
- Cost modeling to implement the program model in both integrated and stand-alone settings, and with the proposed partners.
- Architectural work to refine the "program of space" based on the program model developed.
- Assessment of feasibility of on-and off campus sites for the primary program and campus sites for the smaller capacities based on the refined architectural program of space.

Further term planning milestones include but are not limited to the following.

- Development of partnership agreements for construction/renovation, and management phases.
- Refined cost modeling for program operations and construction/renovation
- Architectural plans, site plans, and construction engineering
- Impact assessments including traffic studies, air pollution, waste water, and impact on the housing, human services and first responders of host communities.

31. **The application indicates (p. 10) that pursuant to 18 V.S.A. §7205 the Department of developmental and mental health services (predecessor to the Division of Mental Health) operates the Vermont State Hospital.**

    a. **Please explain the authorities and roles of the Board of Mental Health (18 V.S.A. §7301) and the State Program Standing Committee.**

The Board of Mental Health voted to disband itself in 1998 and its functions have been largely reassigned. In 1999 through EO 18-12 (also referred to as No. 06-99), then Governor Dean directed that state program standing committees would assume the functions of the defunct Planning Council (role previously assigned to the Board of Mental Health, *see* EO 73A-89) and that current members of the Board of Mental Health would be offered slots on the new state program standing committees.
The roles and authorities of the State Program Standing Committees are governed by Vt. Code R. 12 150 006, Administrative Rules on Agency Designation.

Under the rules, the State Program Standing Committee responsibilities include:

- Advising the Commissioner When Hiring Key Management. "The Commissioner shall seek advice from the Committee in the appointment of a new Division and/or Unit Director."
- Evaluating Quality. The Committee shall review information and advise the Department on the quality and responsiveness of services offered statewide.
- State System of Care Plan. The Committee shall participate in the development of the State System of Care Plan and its updates. In doing so, the Committee will advise the Department in regard to establishing general priorities for resource allocation consistent with the State System of Care Plan.
- Department Policy. The Committee shall review and recommend policy that pertains to or significantly influences services for persons with mental illness. (Rule 3.1, 3.3 – 3.4)

b. **What role, if any, have they played or will they play in the proposals to replace VSH?**

The State Program Standing Committee for mental health has representation on the Futures Advisory Committee. In that role, the State Program Standing Committee will be involved in advising the VDH regarding proposals to replace VSH. The Board of Mental Health, as is, will not have a role regarding proposals to replace VSH.

c. **What role, if any, will they play in oversight, management or governance of VSH replacement facilities?**

The roles that the State Program Standing Committee and the Board of Mental Health may play in oversight, management, or governance of VSH replacement facilities have not been determined.

32. **The application indicates (p. 10) that Vermont's Public Mental Health Services system includes VSH, five designated hospitals, and 11 community agencies designated to provide services…"**
    a. **Please describe the governance of each such institution and explain the extent to which the State governs each institution and the extent to which non-state entities govern each institution.**

The five designated hospitals and the 11 community designated agencies are all private, non-profit organizations, incorporated and governed pursuant to the laws of Vermont, 11b VSA Chapter 8. In addition, the 11 community designated agencies are required to meet the governance requirements of the *Administrative Rules on Agency Designation*, 13 CVR 150 006-6, §4.2. VDH is not aware of any extent to which the state governs any of these organizations.

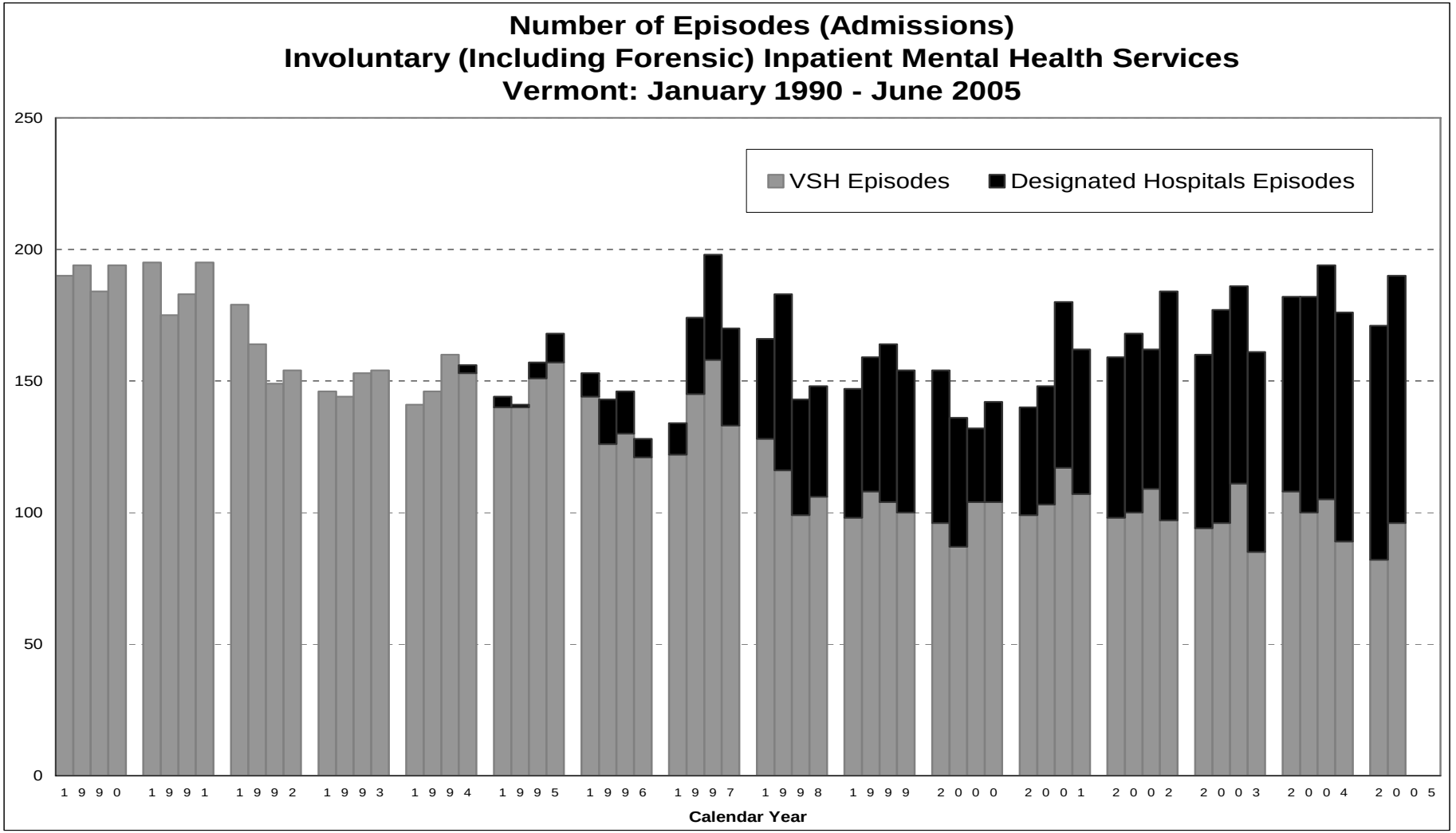
b. **Has VDH determined how a relocation of the services provided at VSH to other facilities will impact governance and control? If so,**

please detail and explain, If not, please explain how and when this will be determined.

VDH has not yet determined how a relocation of the services provided at VSH to other facilities will impact governance and control. This will be determined in Phase II of the planning process.

33. **Please document the shift, described on page 11, beginning in 1994, in the number of involuntary admissions away from VSH as a result of partnerships with other entities.**

See graph below, "Number of Episodes (Admissions) Involuntary (Including Forensic) Inpatient Mental Health Services Vermont: January 1990 – June 2005.



Includes both civil and criminal involuntary hospitalization at the Vermont State Hospital and other designated hospitals.

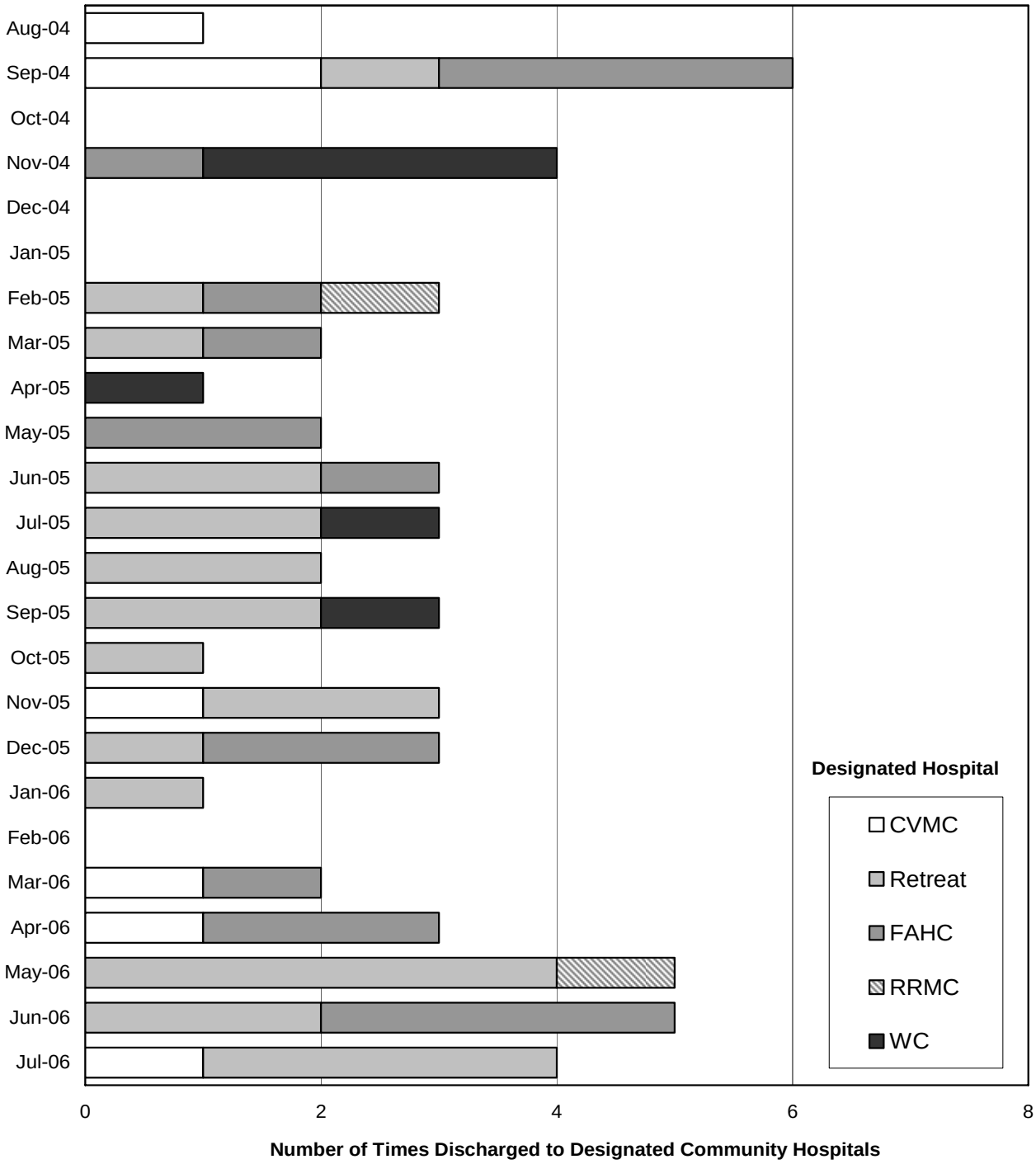
34. **By what authority or mechanism is the census at VSH capped at 54? Why?**

The Vermont State Hospital's hospital license caps the census at 54.

35. **Please provide a matrix providing more detail (perhaps by month and by entity) to the statement that diversion back to designated hospitals occurred approximately 30 times in the past two years.**

See Graph below: **"**Discharges from VSH to a Designated Community Hospital by Month and Hospital August 2004 – July 2006" identifies 57 discharges seen to DH, not 30 discharges as stated in the application.

Discharges from VSH to a Designated Community Hospital
by Month and Hospital
August 2004 - July 2006, (n = 57)



36. **Footnote 13 on page 10 indicates the community mental health centers are the lead agencies with respect to providing comprehensive services to Vermont's priority mental health population, including adults with severe mental illness.**
    a. **How do the CMHC's fulfill this role now with respect to the patients at VSH?**

Every individual admitted to VSH is assigned to a Designated Agency (CMHC) for discharge plan development and aftercare as clinically warranted.

    b. **How will the CMHCs' fulfill this role if the proposed replacement plan is implemented?**

This has not been specifically developed, however, we will likely use a similar process of case assignment.

37. **The application indicates (p. 12) that an unintended consequence of Vermont's emphasis on community treatment has been "under-funding of VSH." Concerns about under-funding of the Futures plan are also evident in the application (see, e.g. the responses by the community mental health centers to the VDH's Request for Information). How does VDH intend to use a conceptual CON planning process to address the potential for under-funding of the VSH replacement programs and/or the community treatment programs?**

The budget development process and allocation decisions are a joint responsibility of the executive and legislative branches. Regarding funding for new psychiatric inpatient programs, the cost modeling proposed during the planning phase of this project should help to more clearly identify for Vermonters what reasonable costs for an accredited program would be.

With regards to the community system, the Agency of Human Services has undertaken planning to address sustainability of Designated Services. The first of two proposed studies, Vermont's Designated Agency System for Mental Health and Developmental Services System Evaluation and Five Year Projections of Service Demand and Cost Analysis, by the Pacific Health Policy Group, was issued in November 2004. A second study will be put out for bid in January 2007 with a report due in August 2007 for FY 2009.

38. **The application (p. 12) indicates both the facility and the programming at VSH "had been such that the program did not meet accreditation standards and the safety of patients was considered at risk." Please explain:**

In February 2005, CMS notified VSH that its provider agreement with CMS had been terminated based on non-compliance with the Medicare Conditions of Participation. CMS cited two Conditions of Participation with which VSH was non-compliant: 482.13(c)(2) and (3) *Patient's Rights: Privacy and Safety* and 482.23 (b)(4)*Nursing Services: Staffing and Delivery of Care.*

Based on an investigation of the facts surrounding the temporary elopement of two VSH patients in the last week of January 2005, CMS determined that VSH had failed to "promote and protect patient rights related to care in a safe environment and to ensure patients were free from all forms of abuse, neglect and harassment." In addition, CMS found that "the facility failed to maintain and/or implement the nursing care plan for two patients in the targeted sample."

a. **In what respects did/does the facility not meet accreditation standards?** See above.
b. **In what respects did/does the programming not meet accreditation standards?** See above.
c. **In what respects did/does the facility pose safety risks to patients?**
d. **In what respects did/does the programming pose safety risks to patients?** See above.
e. **How replacement of the facility will resolve the problems presented in 39 (a) through 39 (d) above?**

The replacement facilities will be constructed in accordance with accreditation standards and with safety measures and optional programming among the priorities. This includes such things as private rooms with appropriate and safe bathroom facilities, proper lighting, access to the outdoors and appropriate meeting rooms for individual and group programs.

Although the goal of the project and the development of VSH replacement facilities are not directly related to the CMS decertification, VDH fully intends to design and implement all new programming and replacement facilities consistent with accreditation standards.

39. **At pages 17-18 the application notes the special role VDH plays in serving particular populations and operating with a "no-reject" admissions policy. How will VDH ensure that successor entities provide the same level of services, maintain a no-reject policy, and serve all of the populations specifically described on pages 17-18?**

VDH is exploring legal options that will ensure that the primary inpatient replacement facility will provide the same level of services, maintain a no-reject policy, and serve all of the populations currently served.

40. **Table 3 on page 19 appears to indicate a significant drop off in total admissions at VSH from 1998 to 1999 and continuing thereafter. Please explain.**

The closing of the Dale unit and development of new community capacities resulted in fewer admissions to VSH. See Graph, "Average Daily Census July 1985 – June 2006" Q 27 above.

41. **The application indicates, on page 19, that 31 percent of the bed days had no source of payment in SFY04.**
    a. **How was this care funded?**

This care was funded through a combination of State General Fund dollars and the Medicaid 1115 B waiver agreement.

    b. **If the responsibility for providing the services is transferred to entities such as FAHC, RRMC and the Retreat, how will the cost for such care be determined and how will such care be funded?**

Costs will be determined through a rate setting mechanism yet to be developed. The care will be funded through a combination of state general funds and Global Commitment (Medicaid) dollars.

42. **What are the "contemporary standards" for care referenced on page 22 under "Clinical Considerations"? Please provide the source documents.**

The "contemporary standards" as used on p 22 refer to recommendations for reforming the delivery of mental health services. These recommendations arise from the evolution of neuroscience of mental health ---"a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena---" [9], The scientific basis for contemporary standards of mental health care now requires a re-conceptualization of the assumptions about, and the language used, in describing the nature of mental illness. It is no longer accurate to split "mental" from "physical" health. "We recognize that the brain is the integrator of thought, emotion, behavior, and health.

[9] U.S. Department of Health and Human Services, National Institute of Mental Health, (1999). Mental Health A Report of the Surgeon General, Preface. (**Attachment 35**)

Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between "mental" and "physical" health."[10]Existing organizational structures for the delivery of mental health services reflect the outmoded science, and contribute to significant disparities in the quality of care available to psychiatric patients. This is especially true for psychiatric inpatients who have co-occurring health conditions.

Considerable work remains, however, to change historically embedded attitudes about, and fear of, people who have mental illness, and to create cultural, service and facility environments that support recovery. The President's New Freedom Commission calls for fundamental change to transform the existing system. In a transformed system 6 goals must be achieved to improve access to quality care and services:

Goal 1: Americans understand that mental health is essential to overall health;
Goal 2: Mental Health is consumer and family driven;
Goal 3: Disparities in mental health services are eliminated;
Goal 4: Early mental health screening, assessment and referral to services are common practice;
Goal 5: Excellent mental health care is delivered and research is accelerated;
Goal 6: Technology is used to access mental health care and information.[11]

43. **Has VDH researched how other states/entities provide care that meets such contemporary standards?**
    a. **If so, please provide the results of such research, indicating, for instance whether other states meet such standards by delivering care at the same site physical health care is provided at or at some other site in partnership with the site where physical health care is provided.**
    b. **If not, please describe how VDH will use the planning authority of a conceptual CON to conduct this research.**

Response to (a) and (b):
In Phase II VDH would perform further search and analyses of the experience of other states in transforming the mental health system, to the extent that this has occurred. It should be understood that the Futures vision (of transforming the mental health system consistent with the concepts of recovery, client centeredness and peer directed services linked to community based and hospital inpatient services) assumes that inpatient services would be provided in the context of current best practice of clinical psychiatry that is consistent with developing knowledge in neurology and neuroscience. Such a reformation of the delivery system has not occurred, to our knowledge, in many places. Vermont's efforts in this direction, based on our best planning efforts to obtain what is desirable for Vermonters, will, in some measure, be defining new territory.

[10] Surgeon General's Report, Preface. (**Attachment 35**)
[11] The President's New Freedom Commission on Mental Health, Final Report (July 2003) pp 4-5.(**Attachment 36**)

44. **What is required, in terms of resources, location, facilities, etc., in order for professionals "to interact with their peers and stay current with emerging trends across the continuum of care" as stated on page 23 of the application? How is it done at other institutions providing quality care?**

The resources that are required are teaching programs, research programs and patients.

The location that is required is proximity sufficient to facilitate meaningful daily interactions between clinicians and patients and among clinicians and with researchers. The necessary facilities are the full array of research, diagnostic and treatment tools and the exchange of information across disciplines within the hospital and between the hospital and the medical education center.

At other institutions the academic environment provided by the university and the teaching programs that are part of the medical school are directly connected to the hospital. These psychiatric programs permit interaction with neurology in a way not possible if the hospital were located in a remote area. Dr. Howard Goldman, Professor of Psychiatry at the University of Maryland School of Medicine, and editor of *Psychiatric Services*, who spoke in September 2006 at UVM Grand Rounds, listed several programs in which state psychiatric facilities are operated by a university affiliated tertiary level hospital as examples of university medical center and public agency collaboration. Dr. Goldman stated that programs such as the Illinois Psychiatric Institute and the New York State Psychiatric Institute are fiscally sound in large part as a consequence of their public-private collaboration. In phase II we will be looking further into these and other, more rural programs, that offer examples of public private collaboration to deliver mental health services.

45. **Please quantify and qualify the statement that "Increasingly, the patients admitted to VSH have complex medical conditions requiring treatment."**

Neither VSH nor VDH routinely capture summarized information on the complexity of patient medical conditions. However some data does exist that details patient medical conditions in October 2000 (See Attachment 11). During the period August 1999 to August 2000 VSH served 266 patients who had an average of 3 major medical diagnoses. There were 210 patient visits to outside medical facilities and 27 patient trips to a medical hospital emergency room. See also the response to Q 113 below and the, "Chart, Severity of Medical Illness at VSH, Inpatient Point in Time Data 1999-2002". For any given year 49 – 59% of VSH patients experience serious or high risk medical co-morbidities.

46. **Please indicate the frequency that applies to the statement that "there was an average of 3 major, medical diagnoses per patient that required active treatment" from August 1999 to august 2000. For example, is this a per month statistic?**

The statistic referenced was per person per hospitalization. Please see the responses to Questions 45 and 113.

47. **Which hospitals provided the 210 patient visits, 3,000 lab tests and 27 emergency room visits referenced on page 23?**

As indicated earlier, data on co-occurring physical health conditions is not routinely collected. The referenced visits and tests are based on CY 2000 data and does not specify the hospitals providing the services. Generally, however, the primary hospitals providing service to VSH patients are Central Vermont Hospital and Fletcher Allen Healthcare.

48. **What is the rate of co-occurring conditions among VSH patients (referenced on page 23) and how is it determined that this rate is "very high"?**

The literature suggests that approximately 15 % of the population in a general hospital psychiatric unit have serious, unstable medical conditions. Medical co-morbidity is present in a substantial number of psychiatric inpatients in tertiary general hospital units. A study of 950 admissions to the Johns Hopkins Hospital Phipps Psychiatric Service found that 20% of psychiatric inpatients had co-morbid conditions while some 15% had serious unstable medical illnesses.[12]

By contrast, 49 – 59% of VSH patients during 1999 – 2002 were classified as serious, high risk patients. See Table "Severity of Medical Illness VSH Patients, Question 113 below.

49. **How are co-occurring conditions defined?**

Co-occurring conditions are two or more health condition requiring medical treatment. With regard to the discussion about VSH, co-occurring conditions may be either two psychiatric – behavioral health conditions (such as depression and substance abuse) or a psychiatric condition and a physical health condition(s) such as schizophrenia and chronic obstructive pulmonary disease. It is the concern of this CON Application that both definitions be adequately addressed in planning for replacement of VSH services.

50. **Page 24 references the characteristics of a specialized inpatient unit, particularly the specialized staffing needed for such units. How have the current personnel at VSH, especially psychiatrists with special expertise, been recruited to work at VSH and what entities/partners provide them? Please provide documentation reflecting how VSH meets its staffing needs. If non State-owned hospitals or entities provide some of the staffing, whether professional, administrative, service or management, please specify the sources and provide relevant documentation.**

With regard to recruitment, the psychiatrists at VSH are employed through state contract with FAHC and are recruited through FAHC's recruitment procedures. Other staffing

[12] C. Lyketsos, G. Dunn, Kaminsky, & W. Breakey (February 2002). "Medical Comorbidity in Psychiatric Inpatiens" *Psychosomatics* 43:24-30. Available online: HYPERLINK "http://psy.psychiatryonline.org/misc/terms.shtml" The Academy of Psychosomatic Medicine (**Attachment 12**)

needs are met through state personnel recruitment procedures. The state uses traveler nurses, locum tenens physicians, and current staff overtime to meet staffing requirements. A copy of the contract with FAHC is appended to this document. (See Attachment 13)

51. **Please document and provide source materials for the statement on page 25 that "specialized inpatient level of care must have easy access to general medical care".**
    a. **What constitutes "easy" access to general medical care?**

The Institute of Medicine standard indicates that care must be timely and equitable, reducing waits and harmful delays and does not vary in quality because of geographic location and socioeconomic status (HRAP pp. xxxi - xxxiv). Easy access to general medical care for inpatient populations should be provided in terms of this standard. Parity of access for treating co-occurring conditions of psychiatric patients requires access times to diagnostic procedures and specialty care comparable to those provided inpatients hospitalized for physical health conditions. Transport of VSH patients by ambulance or Sheriff for inpatient treatment of physical health conditions does not meet the standard of timely, easy or equitable access to care.

    b. **How is "general medical care" defined?**

For the purposes of this application general medical care is all inpatient non-tertiary level care.

    c. **Which hospitals provide such level of care to Vermonters?**

All Vermont community hospitals provide general medical care.

    d. **How is "general medical care" different from tertiary care?**

Tertiary level care provides specialty services, diagnostic assessment and treatment not available in a community hospital, for example, coronary artery by-pass graft procedures or neurological evaluations**.** See also Question 12 b ii.

52. **What is the source, on page 25, of the defining characteristics of a "specialized inpatient service": "optimized for safety", "include[ing] single rooms, an adequate space to allow for physical activity and exercise, and quiet areas to facilitate voluntary regaining of control over one's behavior"?**

The characteristics defined on page 25 of the CON Application are drawn from the Futures Plan [13] Specialized Inpatient Service and Intensive Care Services are terms created in the Futures Process to reflect the more intensive care required by VSH psychiatric patients than exists in Designated Hospitals. These characteristics were

[13] *Vermont State Hospital Futures Plan Report to Charles Smith Secretary Agency of Human Services,* Prepared by Department of Health, Division of Mental Health February 4, 2005, p.26.

identified by Dr. Susan Wehry Medical Director of VSH and Dr. Bill McMains, Medical Director for the Division of Mental Health. (A Designated Hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health --- formerly Commissioner of Developmental and Mental Health Services --- to provide treatment to individuals involuntarily committed to the Commissioner's care and custody. Currently there are 5 Designated Hospitals in VT: Fletcher Allen Health Care, Central Vermont Hospital, Rutland Regional Medical Center, Springfield Hospital of the Windham Center, and Retreat Healthcare.)

53. **What is required, both in terms of facilities and programming, in order to achieve satisfactory levels of the characteristics referenced in question 52 above?**

The characteristics of a specialized inpatient unit include both staffing and architectural attributes. The staffing pattern include:

- Higher RN to patient ratios (one nurse to four patients) than may be found in designated hospital psychiatric units.
- Psychiatrically trained direct care staff (registered nurses and psychiatric technicians or mental health workers) whose core competencies include:
    - assessing and reducing of suicide risk
    - assessing and reducing risk of aggression
    - non-aggressive, humane interventions in the management of violent behavior
    - participation in the creation of individualized plans of care that is trauma-informed and recovery-centered
    - preventing seclusion and restraint.
    - using and teaching recovery methods, including the creation of individualized crisis plans
    - motivational interviewing techniques
    - implementing behavioral plans

- Psychiatrists with special expertise in forensics, in the care of persons with serious mental illness, in substance abuse, in recovery methods, and in trauma care.

In addition, specialized inpatient level of care must have easy access to general medical care. Finally, SIP programs will have ready access to specialty consultations from psychology, neuropsychiatry, and other disciplines.

The physical characteristics of a specialized inpatient service must be optimized for safety, include single rooms, adequate space to allow for physical activity and exercise, and quiet areas to facilitate voluntary regaining of control of one's behavior (commonly known as places of quiet or time-out rooms).[14]

[14] Futures Plan, p 26.

54. **What is the source, on page 25, of the defining characteristics of "intensive care units (ICU)"?**

See response to Q 52 above**.**

55. **What is required, both in terms of facilities and programming, in order to achieve satisfactory levels of the characteristics referenced in question 54 above?**

Characteristics of Intensive Care Units (ICU): This more enhanced version of a specialized unit provides acute, stabilizing care and allows for maximum containment of patients most at risk of violence to self and others. This physical capacity does not currently exist at VSH; individuals with this level of need are managed by increased staffing (1:1 or 2:1 staff to patient ratios) and at present are more likely to require emergency involuntary interventions such as seclusion and restraint to prevent harm to self and others.

The main distinguishing features of the ICU would be: size, configuration of physical space, monitoring capacity, higher registered nurse-to-patient ratios, and a staff with enhanced skill set and experience.

In order to be responsive to the needed patients who have experienced trauma, the SIP and ICU programs will be required to implement the core elements of a trauma informed treatment system including a continuous review of the programs' policies and practices to assure that these do not replicate trauma dynamics for patients and staff. (Futures Plan, pp 26-27.)

56. **Please detail the "distinguishing features of the ICU", providing any information you have to date that informs VDH as to standards, guidelines or recommendations VDH is aware of that indicate what the "size, configuration of physical space, monitoring capacity, higher registered nurse-to-patient ratios, and a staff with an enhanced skill set and experience" need to meet.**

The characteristics drawn from the Futures Plan and described in the responses to Q 53 – Q 56 represent the formulation of standards available to date. Greater specificity will be detailed as part of Phase II planning activities.

57. **Please explain how replacing the buildings in which services are now offered is relevant to not "replicat[ing] trauma dynamics for patients and staff." (p. 25)**

Current VSH physical space limitations require co-mingling patients on large units and in shared rooms. These limitations make it impossible to effectively separate incompatible

individuals and groups. Many individuals who come to VSH have a history of trauma and abuse. Other individuals exhibit patterns of aggressive behavior and discontrol. Mixing these patients creates a milieu in which those with prior histories of trauma and physical abuse do not feel safe. This is the meaning of the statement that current physical space at VSH replicates trauma dynamics for patients and staff.

58. **Please explain what is meant by "complex transport by ambulance or sheriff" as referenced on page 25. Provide relevant policies and elaborate by providing numbers of instances of transport broken out by means of transport, reasons for transport, and procedures followed for differing types of transport or reasons for transport. Please provide the information for the last three years, either fiscal or calendar.**

Complex transport refers to situations when patients are transported from one institution to another by ambulance or by Sheriff and / or security personnel. The complexity results from trying to assure medical and security needs and manage patient behavioral discontrol across geographic distances. Arguably every ambulance transport is complex because of the nature of medical emergencies. Because of the characteristics of VSH patients the situations of ambulance transport are particularly complex.

VSH does not routinely track the number of transports, reasons for transport and procedures followed for different types of transport. Data provided by Washington County Ambulance Service indicates that during the last 3 fiscal years ambulance transport was used 61 times. The reasons for transport were for medical evaluation and treatment. See attached, "103 South Main Street Calls, "and "VSH calls FY05- Fy-07."(Attachment 14) Transport policies are attached.(Attachment 15)

59. **What are the "secure, alternative Transportation options to the current system of using sheriffs" referenced on page 33 and what is the plan for achieving the "additional resources for transportation costs" that may be necessary "due to geographical distribution of programs."**

These are under development and will be completed in Phase II.

60. **Specifically referring to each of the preferred facility options, how will the transport issue referenced above be affected by the proposed replacement of VSH?**

We would expect that transport needs will be fewer because more patients will be onsite at Fletcher Allen Health Care and RRMC. Moreover, people will be appropriately triaged early on and treated sooner. It is expected that this will result in a decline in the number of emergency transports required and that transports themselves will become less complex.

61. **In what ways, specifically, do the community hospitals "currently lack the clinical and physical security capacity to provide the VSH level of care"? (p. 25)**

Community hospitals without a psychiatry program have no ability to serve involuntary psychiatric patients, and as such are not "designated" to provide involuntary inpatient psychiatric care. They cannot legally provide such services. VSH level of care is almost exclusively involuntary. Designated Hospitals with general psychiatric inpatient programs lack capacity for emergency involuntary interventions, staff and security procedures to address the needs of patients currently referred to the VSH. The designated community general hospital psychiatric programs security procedures and practices are developed with a primarily voluntary patient population in mind. (For example FAHC may have 6-8 visitors at any given time moving freely about on its current psychiatric ward, a condition that could create safety and security problems with VSH patients). Finally, none of the Designated Hospitals have the capacity for one-to-one staffing provided by psychiatric technicians at VSH. Psychiatric technician roles do not currently exist in these hospitals. This is why two new, more intensive levels of care (intensive and specialized) are proposed.

62 **The application, at page 25, indicates that in SFY 04 the operating cost for VSH was $13,520,510. Please provide:**

a. **The operating costs for VSH for SFY 05 and SFY 06 and the projected operating cost for SFY 07**

SFY 05 - $15,032,748
SFY 06 - $17,271,537
Budgeted SFY07 - $18,708,479

b. **The operating costs identified in 62a above calculated per adjusted admission**

VSH does not calculate operating costs per adjusted admission.

c. **The operating costs per adjusted admission, for comparable time periods, for the inpatient psychiatric programs at FAHC, RRMC and the Retreat**

According to Mike Davis of BISHCA, FAHC, RRMC and the Retreat do not calculate operating costs per adjusted admission for inpatient psychiatric programs.

d. **Please explain factors that account for differences in the operating costs per adjusted admission of the programs at VSH, FAHC, RRMC and the Retreat**

VSH does not calculate adjusted admissions costs and therefore, we cannot compare these costs with FAHC, RRMC and the Retreat. VDH can only account for the operating costs that occur at VSH.

63. **Especially in light of the Health Resource Allocation Plan's data about workforce shortages in Vermont's health care system, how, specifically, will VDH use a conceptual CON to determine:**

    a. **Staffing needs at replacement facilities**

One of the Phase II tasks will be to refine the program model including staffing patterns**.**

    b. **Recruitment and hiring practices and policies related to meeting such staffing needs**

We will work with our inpatient partners to develop recruitment strategies and hiring practices.

    c. **Ensuring that the current workforce at VSH, described in the application (p. 26) as "uniquely qualified, by virtue of experience and training, to provide specialized and intensive psychiatric inpatient services in the future", is utilized for the good of patients in need and for the good of the State**

We have a high priority to maintain the current qualified workforce.

64. **The application (p. 26) concludes a section about the VSH replacement by indicating "the capacity at VSH needs to be replaced with new inpatient and community programs that are responsive to current and future needs of Vermonters in need of mental health service." The importance of community programs as a critical part of the plan to replace VSH is referenced throughout the application. One such reference concerns the actuarial projections of bed need, indicating different levels of bed need depending on the extent to which community programs are implemented.**

    In order for the Public Oversight Commission to make findings and recommendations on VDH's CON applications (both Conceptual and Phase II), and for the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (Commissioner) to issue decisions on the applications, they will have to know the extent to which the community programs will be implemented. How, and when, will VDH determine this and provide the information?

We plan to implement the community programs detailed in the March 2006 Report to the Legislature[15]. The Legislature accepted the recommendations and allocated funds. We are currently working to implement the recommendations of the report. We have specific allocation in the FY 07 budget for the following: (1) New Residential Recovery and Secure Residential Treatment Programs, (2) Crisis Beds for Stabilization and Diversion, (3) a Care Management Program, (4) Peer Services, and (5) Transportation.

65. **What is meant by "isolation of the program from the rest of the inpatient care system" (p. 26) and how, both in terms of facilities and programming, will the proposed plan positively address this issue?**

By this statement we mean that the current VSH program is separated physically and clinically from many of the resources it needs. By partnering with the hospitals designated in our preferred option we propose to address this issue per the programmatic elements of the Futures Plan.

66. **The application calls for Vermonters hospitalized for acute psychiatric inpatient care to "have access to the same diagnostic and treatment facilities as all other Vermonters."**
    a. **Does this level of access require that all such needed diagnostic and treatment services be provided at Vermont's only academic medical center and tertiary care facility (FAHC)? Please explain.**

No. Some care will happen at community hospitals. Patients require a full array of services. Some can be provided at community level care. Others must be provided in tertiary care facilities. When tertiary level care is needed, that care should be readily available.

    b. **Does this level of access require particular diagnostic and treatment services be provided at FAHC? Please explain.**

When clinically indicated, yes.

67. **The application indicates stigma would be eliminated (p. 26) by implementation of the project.**
    a. **How does VDH define stigma in this context?**

In this context we define stigma as separate and unequal.

[15] *The Vermont Mental Health Futures Plan Proposal to Transform and Sustain a Comprehensive Continuum of Care for Adults with Mental Illness Presented to the Legislative Mental Health Oversight Committee March 22, 2006, Approved by the Committee with Two Amendments, Revised April 25, 2006* and appended as Appendix C to the August 17, 2006 Certificate of Need Application

b. **Please explain the extent of the current stigma problem and what factors are believed to contribute to it.**

Stigma factors have been clearly identified by *The Surgeon General's Report* (See Question 42) and *The President's New Freedom Commission Report* .(See Question 43) Perhaps the most comprehensive discussion of stigma is found in *The Surgeon General's Report* which identifies stigma as based in public attitudes of fear and discrimination against people who are mentally ill. Such attitudes create and reinforce institutional barriers to provision of appropriate care and result in inequitable insurance payments for treatment services. "Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders…. It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity, and interferes with their full participation in society. *The Surgeon General's Report* identifies one source of stigma as the "19th century separation of the mental health treatment system in the United States from the mainstream of health."[16] The separation of patients based on psychiatric diagnosis at VSH additionally extends stigma into the realm of medical services and violates the Institute of Medicine standard for provision of timely and equitable care.

c. **What does available research indicate as ways to eliminate or reduce such stigma?**

According to *The Surgeon General's Report*, "there is likely no simple or single panacea to eliminate the stigma associated with mental illness." [17] Strategies that may prove useful include provision of empirically based information on the association between violence and severe mental illness, provision of advocacy programs, public education, and contact with persons with mental illness through schools and other social institutions. Another strategy is to find causes and effective treatments for mental disorders. Finally, clinical integration of treatment for all health conditions is considered an essential strategy to reduce the institutional dimensions of stigma that promote separate and unequal access to care.

d. **How would implementation of the project eliminate or reduce such stigma?**

By providing parity of access to physical health care and achieving more clinical integration of psychiatric inpatient care with all other forms of inpatient care

68. **Regarding the goals expressed on page 27 of the application:**

[16] Surgeon General's Report, p 6.
[17] Surgeon General's Report, p 8.

a. **How would achieving those goals (please respond separately regarding each one) address particular findings by the Department of Justice regarding care at VSH?**

The goals then that this project hopes to advance include:

- **Increasing citizen's access to the services and healthcare that they want and need;**

Increasing citizen's access to the services and healthcare that they want and need is unrelated to the particular findings of the Department of Justice regarding care at the VSH.

- **Improving program quality and consumer satisfaction**;

Improving program quality specifically at VSH will address the specific findings by the Department of Justice in the areas of: treatment planning, assessments and diagnoses; psychiatric and psychological services, rehabilitation therapy services, and pharmacy services. There are no specific findings by the Department of Justice relating to consumer satisfaction at VSH.

- **Designing programs and services that are consumer and family driven;**

Achieving the goal of the Futures Plan relating to consumer and family driven services will address the particular finding by the Department of Justice of inadequate treatment planning. In the settlement agreement the State agreed to include VSH consumers/patients on their treatment planning teams. A VSH consumer/patient may also choose to have a family member involved.

- **Insuring programs are responsive, sustainable and efficient over time;**

Insuring programs are responsive, sustainable and efficient over time is unrelated to the particular findings of the Department of Justice regarding care at the VSH.

- **Improving the health and integration of citizens with disabilities in their home communities.**

Improving the health and integration of citizens with disabilities in their home communities is unrelated to the particular findings of the Department of Justice regarding care at the VSH.

b. **How will replacing the VSH facilities serve to achieve those goals?**

Replacing VSH facilities will provide a physical space for inpatient mental health care that will facilitate care that is consistent with current standards for treatment and safety.

A new facility can be designed with current and expected AIA standards in mind for inpatient care. This includes safety features, single rooms, adequate space for activities and treatment, optimal positioning of nurses stations, and the ability to create smaller-scale milieus than the current VSH affords. Such features would improve the environment of care.

c. **To what extent is achievement of the goals not dependent on construction of particular new or renovated facilities but rather on changes to systems, programs, policies, practices, training, staffing, protocols and so forth?**

The achievement of these goals is not solely dependent on construction of new or renovated facilities. The systems, programs, policies, practices, training, staffing and protocols in new inpatient programs will also impact on achieving these goals. Detailed program design work is expected to occur in Phase II.

69. **Please define and describe what VDH means by "secure residential facility" (e.g. page 28) and indicate:**
    a. **How many beds VDH believes the secure residential facility will require for each year from 2010-2020**

The Futures Plan currently proposes 6 beds for secure residential care. We did not do actuarial projections on community services. The secure residential facilities are part of the community based system and outside the scope of our CON planning.

b. Where such beds would be located and in what type of facility(ies)

This remains to be determined.

c. What entity(ies) would fund, staff, and govern such beds, and how, and

This has not yet been determined.

d. How the care provided in such beds would meet the goals described throughout that application such as the goals of providing integrated care and ensuring access to care that is the same as all other Vermonters have access to

This remains to be determined.

70. **The application references (p. 28) a recommendation of "Locating services in or near the most appropriate setting: academic medical centers, community hospitals, or other community based facilities" but does not**

indicate preferences for particular academic medical centers, community hospitals or community based facilities or how to prioritize them. Please specifically explain the process and rationale that resulted in the application recommending construction of replacement VSH facilities at or in conjunction with one of the two academic medical centers that serve Vermont. Please provide documentation and other materials needed to put the reply in context.

Since FAHC was a willing partner and because there is not a practical way to provide emergency involuntary care across state lines VDH worked with our in-state tertiary care facility.

The reference on page 28 is taken from the HRAP verbatim and reflects its recommendations. VDH recommends integrating the primary new inpatient program with FAHC, Vermont's in-state tertiary, academic medical center.

The minutes and conclusions of the Futures Advisory Committee inpatient work group that developed this policy recommendation are included as attachment 16.

71. **Please describe the "thorough clinical and operational planning process that includes the State's hospitals." (p. 28) If this has not been accomplished please explain how the conceptual CON will be used to accomplish this.**

The HRAP (and thus the related CON standards) recognize that the Futures planning process is a thorough clinical and operational planning process. All of the states' hospitals are represented in this process.

72. **Regarding the crisis beds referenced throughout the application (e.g. p. 29):**
    a. **How does VDH define such crisis beds and what is their role in the system of care?**

The role of crisis beds is to provide early and immediate care to help individuals stabilize their functioning and to divert or reduce the need for hospital care. They also provide step-down and transitional care to reduce the length of stay at VSH.

    b. **How many such beds exist now and where are they located?**

There are 19 such beds located in Bennington, Windham, Washington and Chittenden counties.

    c. **How many such beds does VDH plan to implement as part of the project?**

We plan an additional 10 beds.

d. **Where will they be located and/or what factors will determine location?**

This remains to be determined.

e. **How does the successful implementation of the crisis beds impact the projected need for ICU, SIC and general inpatient psychiatric beds to replace VSH?**

The implementation of the 10 additional crisis beds was factored into actuarial estimates of beds needed. Refer to the Milliman Actuarial Report attached as Appendix B to the August 17, 2006 Certificate of Need Application.

f. **How will be the crisis beds be coordinated and integrated into the inpatient psychiatric system of care?**

Coordination and integration of inpatient and crisis beds will occur by means of the proposed care management system.

73. **The Futures Plan is presented on page 29 as including (item f) the "enhancement and sustainment" of eight "existing delivery system elements". Please provide:**
    a. **A status report on each of these elements**

The report to the Legislature in March 2006 attached as Appendix C to the August 17, 2006 Certificate of Need Application provides the most recent update on elements (a) through (e). Additionally, Futures Project Work Groups on crisis beds, care management and housing are in process. The reports of these work groups will inform Phase II planning activities.

b. **An explanation of how VDH expects to enhance and sustain funding for components 1 through 7 while also funding the project to replace the facilities and relocate the services of VSH**

Planning for system wide sustainability is in process. The state's current sustainability study[18] does not specifically reference the 8 elements cited in the question. This study does address the financial sustainability of the Designated Agency System that is responsible for providing outpatient continuum of care services for Vermont's adult mental health outpatient population. The results of this study included recent Legislative action granting a 7.5% General Fund increase to the Designated Agencies each year for three years. The Request for Proposal for the second sustainability study is to be issued

[18] *Vermont's Designated Agency System for Mental Health, Substance Abuse & Developmental Services System Evaluation and Five-Year Projection of Service Demand and Cost Analysis*, The Pacific Health Policy Group, November 1, 2004.

in January 2007 with a report expected in August 2007 for FY'09 fiscal planning puposes.

74. **How will implementation of this project improve the following problems identified in Secretary Charles P. Smith's report of February 4, 2005 (p. 30):**
    a. **"…services are not well coordinated across the continuum of mental health care, from primary care providers to the community partners, to the designated hospitals, to the VSH and prisons…"**

The Care management system currently in development will improve coordination across the continuum of care.

    b. **"…the community mental health system has faced increasing demands for service, with limited funds allocated for cost of living and inflationary pressures."**

The costs and supports for the overall Community Mental Health System (CMHS) are being considered by the Legislature in the context of the sustainability study referenced in Q 73.

    c. **"…many Vermonters in need are not receiving services."**

The sustainability studies address case load pressures and unmet need and provide recommendations designed to make system funding and services predictable.

75. **Why does the plan call for new inpatient programs at a primary and secondary location "be operated under the license of host hospital(s)" rather than under the license of the State?**

Operating under the license of the host hospital assures clinical, programmatic and operational integration by providing a single entity to manage the service.

76. **Regarding legal services, both civil and criminal, needed by patients at Vermont State Hospital:**
    a. **Please describe the scope, funding, and processes for providing such services currently**

Three publicly funded (state and federal) entities currently provide legal services to patients at VSH: 1) Vermont Legal Aid Mental Health Law Project represents patients at Family Court proceedings for commitment and involuntary medication proceedings, 2) Office of the Public Defender represents indigent patients at District Court for criminal proceedings, and 3) Vermont Protection and Advocacy provides general advocacy to people with mental illness including patients at VSH. In addition, occasionally patients will retain the services of private counsel to represent their interests.

b. **Please describe how the scope, funding and processes for providing such services will need to change if the project is implemented as planned**

We have not yet decided how or whether the scope, funding and processes for providing legal services to patients at VSH replacement facilities will need to change. We will work with the patient attorney groups during the Phase II planning as we make those decisions.

c. **Please describe VDH's plans to accomplish the needed changes** NA-See Above

77. **What degree of physical co-location of services is required to achieve the recommendation set forth on page 31 of the application that "The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services."?**

The preferred option is for physical connection with inpatient care services. The feasibility of this will be fleshed out further in Phase II.

78. **The application indicates plans for and a need for a secure residential treatment facility but it appears inconsistent as to how many beds are needed in such a program, calling in some places for 6 such beds and in other places for 8 such beds (see, e.g. page 32 and appendix A. Also see pp. 67-68 where it indicates a need for six secure residential care beds to serve "four to eight individuals at any given time"). Please explain.**

The Futures Plan has always called for 6 secure residential beds. Planning assumes dynamic flow of patients through the system. We believe that this will meet capacity need most of the time. On occasion when it doesn't we will use other community and inpatient resources to accommodate the overflow.

79. **Please explain the role the Department of Corrections (DOC) has played to date in the development of the project and indicate:**
    a. **If the DOC has approved or endorsed the application**

The Department of Corrections has participated in the development of this plan and is represented on the Futures Advisory Committee**.**

b. **How the VDH and the DOC will partner to implement the project**

VDH and DOC regularly collaborate on treatment of incarcerated Vermonters and will continue this collaboration.

80. **Please explain how the project will "incorporate the needs of certain populations served by the Department of Corrections"? (p. 81)**

The Department of Corrections (DOC) has participated in the Futures Advisory Committee and the planning process. Currently, VSH and the DOC collaborate clinically and inmates are transferred to VSH. The actuarial study and the planning process to date has taken the utilization of psychiatric inpatient services on behalf of incarcerated Vermonters into account. From a programmatic and clinical perspective, the core issue is to have the architectural and staffing capacity to manage potentially aggressive individuals regardless of their legal status.

81. **Please explain how the project will address the identified need for new supportive housing resources: "consistently identified …as one of the most significant unmet needs of Vermont's citizens with mental illness." (p. 34)**

Addressing the housing needs of Vermonters with mental illnesses is beyond the scope of this planning application for new inpatient services. However, a Future Advisory Committee work group is focusing on housing and will develop recommendations for the full Advisory Committee and for the Secretary of the Agency of Human Services to consider.

82. **Please explain how success in addressing the housing need identified on page 34 of the application will impact the need for replacement beds for VSH. Specifically, has VDH been able to quantify, or does it have plans to research and quantify the relationship between housing supply and need for inpatient beds?**

Adequate housing will facilitate discharge and limit the need for additional inpatient beds. VDH has not quantified the exact impact requirements. We will rely on the Futures Housing Work Report to address this issue.

83. **The application indicates (p. 34) that planning for the inpatient and community services "needs to occur in the context of considering the overall financial health of the designated hospital and agency service providers." Please either provide documentation of such planning conducted by VDH or indicate what the plan is to conduct such planning.**

VDH will rely on the AHS System Evaluation and Five Year Projection of Service Demand and Cost Analysis for planning for the financial health of the Designated Agency Service Providers. The most recent report dated Nov 1, 2004 produced by the Pacific Health Policy Group models strategies to address sustainability. The Agency of Human Services is in the process of developing an RFP for a second "sustainability" study and these findings from this planning process will inform the overall sustainability strategies used by AHS.

84. **Please describe the Health Care & Rehabilitative Services (HCRS) "program for cost-effective management of pre-CRT individuals" noted on page 34 of the application, explain what resources will be needed to implement the called-for replication of that program in other areas of the state, and indicate how the resources will be obtained and the plans implemented.**

This program administered by HCRS, provides counseling, outreach, and case management services to adults and families who are not categorically eligible for other long term support programs. Described as "pre-CRT" the intention is to provide support to help prevent crises or further deterioration of a person's functioning. This program is part of the Designated Agency outpatient services programs. Additional resources for Designated Agency Outpatient programs are included in any increased allocation appropriated by the Vermont Legislature.

85. **How will the other enhancements noted on page 35 of the application (expansion of the co-occurring disorders project, public health prevention and education strategies, and offender out-patient services & mental health plan for corrections) be resourced and implemented?**

The resources for these programs will be identified by the Departments of Health and Corrections through the normal budgetary process and appropriations request. The programs will also be implemented by the responsible Department consistent with the received appropriation. These enhancements are complimentary to but outside the parameters of this CON.

86. **Please provide the VSH strategic plan referenced on pages 35-36 of the application.**

See attachments for Q86 appended.(Attachment 17)

87. **Please provide the referenced "analysis of the options for inpatient partners" that was conducted (p. 36).**

The Inpatient Partner Option Analysis is derived from the *Vermont State Hospital Futures Plan Report* [19], and is summarized on pp 36-52 of the August 17, 2006 CON Application. There is currently no other analysis. The analysis will be expanded in Phase II planning.

88. **Please explain how VDH conducted the referenced "consideration of costs including the IMD issue". (p.36)**

VDH conducted the referenced "consideration of costs including the IMD issues" at a very global level. VDH considered the current operating costs at VSH, the payor mix at

[19] *Vermont State Hospital Futures Plan Report to Charles Smith, Secretary Agency of Human Serv*ices Prepared by Department of Health Division of Mental Health February 4, 2005.

VSH and at the partner hospitals and the potential impact of IMD status on the yet to be developed operating costs. Currently work-groups are developing the program models for the various in-patient programs. In Phase II of this project, VDH will look in more detail at how those program models cost out at the various partner hospitals.

89. **Please explain the limitation of consideration of "interest of potential partner(s) to provide specialized inpatient psychiatric care". Does this mean potential partners' interest in providing general inpatient psychiatric care was not considered? Please explain.**

This reference means that only hospitals that expressed an interest in providing specialized inpatient psychiatric care were considered. Hospitals that indicated they were not interested were not considered.

90. **How did VDH determine "ability to attract and retain staff? (p. 36)**

VDH relied on hospital recruitment experience and historical staffing challenges as documented in HRAP: "Psychiatry is recognized statewide as a specialty in short supply, particularly in child and adolescent disciplines and in rural areas." (p. 235) Also noted in HRAP… "There is a growing need for psychiatric nurse practitioners in view of the limited supply and maldistribution of psychiatrists and growth in population-based need for mental health services." (p.243) The literature regarding nursing shortages in general is abundant. (See HRAP, p.254, Nursing Professionals.)

91. **How does VDH define the "necessary critical mass to develop a strong program" and how was this determined? (p. 36)**

The necessary "critical mass" refers to the aggregation of patients, providers and financing to create an effective and viable program. The critical mass reference here is conceptual and not quantified.

92. **Regarding Northeastern Vermont Regional Hospital's interest in and ability to partner with the State to provide inpatient psychiatric care (see, e.g. p. 37) please document:**
    a. **any requests to NVRH that it consider operating "VSH replacement inpatient services"**

At the request of Dr.David Fassler, Deputy Paul Blake and Beth Tanzman met with Paul Bengston on October 14, 2005. Attachment 18 is the letter (dated 10/28/05) that Ms. Tanzman wrote to Mr. Bengston summarizing the discussion as she understood it.(Attachment 18)

    b. **any responses from NVRH regarding operating "VSH replacement inpatient services"**

The RFI attached to the August 17, 2006 CON Application as Appendix A was sent to all Vermont hospitals. NVRH did not respond**.**

NVRH was invited to the August 31, 2004 informational session and did not attend. The December 2004 Request for Information was distributed to all hospitals, NVRH did not respond. Neither Deputy Blake or Beth Tanzman received a response to the October 28, 2005 letter summarizing the meeting held earlier that month.

93. **Please document Central Vermont Hospital's (CVH) response(s) to VDH's inquiries regarding CVH's interest in participating in the project, both with respect to provision of mental health care and physical health care.**

Central Vermont Hospital has not responded in writing to any requests to partner in providing new inpatient psychiatric services. Central Vermont Hospital currently provides physical health care services to VSH inpatients when clinically indicated.

94. **The application notes, on page 39, that "Medicaid payments for inpatient psychiatric care at general hospitals were not affected by [the IMD] policy change because they were *not* classified by CMS as IMDs." (emphasis in Original). Please explain:**

    a. **For FAHC and RRMC, what percent of the hospitals' costs for inpatient psychiatric care were reimbursed by Medicaid in hospital fiscal years 2004, 2005 and 2006 (projected).**

FAHC: FAHC received reimbursement from Medicaid equal to the following percentages of its direct costs (exclusive of indirect costs) for inpatient psychiatric care of Medicaid patients for the fiscal years indicated: FY 2004 – 116.0%; FY 2005 – 106.3%; and FY 2006 – 94.2%.

RRMC: For the years 2004, 2005 and 2006 Medicaid covered 120%, 114% and 108% of inpatient psychiatric costs respectively.

    b. **How implementation of the project would affect the percent of the hospitals' costs for inpatient psychiatric care to be reimbursed by Medicaid**

FAHC: FAHC has indicated that if any new inpatient facilities operated by FAHC as part of the project are classified as an IMD, Medicaid patients would be ineligible for Medicaid reimbursement for care received in the facilities. This would seriously and adversely affect the percent of FAHC's costs for inpatient psychiatric care reimbursed by Medicaid. The future IMD classification of new psychiatric inpatient services has yet to be determined.

RRMC: It is unclear how costs would be covered with the implementation of this project. Reimbursement levels have not yet been agreed to with the State.

c. **How implementation of the project would affect the payment of the hospitals' costs for inpatient psychiatric care for Medicaid patients**

FAHC: FAHC has indicated that if any new inpatient facilities operated by FAHC as part of the project are classified as an IMD, Medicaid patients would be ineligible for Medicaid reimbursement for care received in the facilities. This would seriously and adversely affect the percent of FAHC's costs for inpatient psychiatric care reimbursed by Medicaid.

RRMC: It is unclear how costs would be covered with the implementation of this project. Reimbursement levels have not yet been agreed to with the State.

95. **Is "simultaneous access to psychiatric and physical health care" (p. 39) the standard of care? Please explain.**

In many respects the standard of care is culturally-specific. Standards of care vary across regions even among the same specialties. The standard of care is most often directly related to the resources available to a given community. In Vermont, the standard of care is care that meets the IOM aims as set forth in the Principles for the HRAP. The American Psychiatric Association gives further guidance as to what the standard of care ought to be for mental health care. In pertinent part, the APA states, "Since mental illness and substance abuse occur together so frequently, mental health care should be fully integrated with the treatment of substance abuse disorders and with primary care and other general medical care services." The APA also advocates for "Health benefits, access to effective services, and utilization management must be the same for people with mental illness as for other medical illnesses, preferably funded by integrated financing systems. Although states are the ultimate locus of responsibility for the public safety net, the federal government and the private sector employers must also support an increased investment in the mental health of Americans." [20] Through health policy planning in Vermont, including the HRAP and the Futures Planning, VDH strongly believes that the standard of care for inpatient mental health care is being adopted and formalized in the process of planning for VSH replacement services. That standard is to physically co-locate mental health services with other general medical health care services.

96. **Given that Northwestern Medical Center (NMC), Brattleboro Memorial Hospital (BMH) and Southwestern Vermont Health Care (SVHC) are located within reasonable commuting distance to hospitals with significant inpatient psychiatric care programs (FAHC, Retreat HealthCare and Albany Medical Center, respectively) how and why has VDH concluded (p. 45) that "it would be difficult for" NMC, BMH and SVHC to "develop program and**

[20] *A Vision for the Mental Health System,* American Psychiatric Association, April 3, 2003.(**Attachment 19**)

staff infrastructure required to operate psychiatric inpatient care at the specialized program level?"

The specialized program level requires additional staffing and the ability to manage more complex and acute clinical presentations than does the general hospital level of care. The Division based its conclusion on feedback from medical and program directors currently operating general hospital psychiatric units (see for instance minutes of the Futures Advisory Committee Inpatient Work Group).

97. **The application presents capacity assumptions of 90% and 95% (see, e.g. pp. 45 and 57), discusses a need to have adequate "surge" capacity (see Appendix A, for example, the Request for Information, which indicated a need for "sufficient 'surge' capacity to meet expected spikes in demand), and notes that VSH, and its replacement facilities must have a "zero reject" policy.**
    a. **Given the need for the zero reject policy in order to ensure needed treatment for the most seriously mentally ill patients and to meet the public good, why is the VDH not planning to be able to meet 100% of projected capacity?**

Projections of 90% and 95% are based on current utilization patterns at VSH. See Chart, Q 27 above, "VSH Average Daily Census, July 1985 – June 1006".

    b. **How will the VDH and its partners serve those in need at times when the planned-for capacity of 95% is filled?**

In the event of surge requiring 100% capacity, additional bed need would be managed through the care management system.

98. **Regarding Table 7 on page 47, it appears the non-mental health average daily acute care censuses were not adjusted, as were the mental health average daily acute care censuses, to account for utilization growth between 2004 and 2014. Either explain that this has been factored in or revise the table to include a column for "all other acute care ADC 2014" in between the columns for "Total MHADC 2014" and "Total ADC 2014".**

The general historical trend of acute care daily census (non mental health) has declined over the period 1995-2004. Assumption 3 on p 45 of the CON Application addresses the complexity of variables resulting in the decision to assume no growth in non-mental health average daily acute care census.

99. **How did VDH "[solicit] the interest of all of Vermont's hospitals"?**

The Division used several mechanisms. VDH solicited the participation of the Vermont Association for Hospitals and Health Systems on the Futures Advisory Committee. An

informational session early in the planning process was held on August 31, 2004 to which all hospitals were invited. The Request for Information was sent to all of Vermont's hospitals. A summary (August 17, 2005) of the results of this inquiry is appended (Attachment 20). In addition, in October of 2005, Deputy Paul Blake personally called each hospital CEO to review their level of interest.

100. **What, if anything, did VDH do to solicit interest from hospitals in neighboring states with a presence in the Vermont health care sector?**

VDH did not solicit interest from hospitals in neighboring states because of the barriers associated with out-of-state partners. See answer 13(c) above.

101. **Regarding the Request for Information (appendix A) issued December 16, 2004 with a due date of December 31, 2004, it is noted that some respondents cited the difficulty of responding to such a request during last two weeks of the year. This included the period of the Christmas and New Year's Eve holidays. It also appears some of the responses were cursory in nature (citing the timing of the RFI as a reason) when responding to the "guidelines for respondents". Given these factors:**

a. **How valuable does VDH believe the responses are as a gauge of interest in providing the services needed?**

The respondents most interested in participating in a partnering arrangement came forward through the RFI process. VDH believes these responses accurately reflect interest.

b. **Did VDH follow a process to mitigate the potential negative impact of the timing and timeline referenced above?**

VDH made follow-up calls. Vermont Hospitals were invited to participate in the Advisory Committee and had the opportunity to exchange information and engage in project work groups. Those operating Psychiatric Services were either present or were represented by the Vermont Association of Hospitals and Healthcare Systems (VAHHS) on the Advisory Committee.

c. **Please explain why the responses from FAHC, RRMC and Retreat Healthcare are dated on or before the RFI issue date of December 16, 2004.**

This was not a formal bid process, simply a request for information. Additional access was obtained through the planning process detailed above. Earlier drafts of the request had been circulated to VAHHS to solicit feedback from the hospitals prior to issuing the RFI. We had requested and received prior commentary on drafts of the final materials that were issued on December 16, 2004. There were no substantive differences between

the last draft and the final RFI. Given this and the timing of the final posting of the RFI we assume FAHC, RRMC and Retreat Healthcare were referencing the earlier draft materials in their response.

102. **Please document the statement in the application that "The leaders of Vermont's inpatient psychiatric programs feel it will be extremely difficult for a hospital without experience in these areas to create such a program…" and identify these "leaders". (p. 51)**

Minutes from the November 1, 2005 meeting of the Inpatient Work Group (Attachment 21) document the leaders present and the resolution passed. They passed a resolution suggesting the sites and partners. On November 16th, the recommendations were ratified by the full Futures Advisory Committee (Attachment 22) with some additional language (provided in correspondence dated September 13, 2006 to Bruce Darwin Spector, (Attachment 23).

The leaders reference on p 51 of the CON Application included Richard Palmisano, CEO Retreat Healthcare; Peter Tomashow Psychiatric Medical Director, Central Vermont Hospital; Todd Centybear, Executive Director, Howard Center for Human Services; JoEllen Swaine, Director of Social Work VSH; Larry Thomson, Director of Psychology, VSH; Bob Pierattini, Chief of Psychiatry FAHC/UVM: Stuart Graves, Medical Director Washington County Mental Health; Bea Grause, VAHHS; and other members of the VSH Futures Work Group. See Minutes (Attachment 21) of November 1, 2005 meeting.

103. **Regarding Table 9 on page 52 of the application:**

a. **Why hasn't a process been developed to weigh the relative values of each criterion?**

"High," "low" and "medium" relative values were assigned to the various criteria as a first step and provided a qualitative framework for evaluating potential partners; further definition and examination will be developed in Phase II planning as necessary.

b. **Without knowing the relative value of each criterion how has VDH compared potential options against each other?**

The comparisons made were based on an over-all assessment, given the current information available.

c. **Why is FAHC (second column from the left) rated as "High-Medium" in terms of retaining the current VDH workforce?**

FAHC is located in a more urban area and is an academic medical center. The potential for attracting the necessary work force is greater than in non-urban areas where there is

less opportunity for further education and research. In addition, Burlington is within 30 miles of the VSH, offering a feasible commute for the current workforce. (See the HRAP, Section Three: Chapter 2, Specialty Care Services, p.129.)

d. **It appears the Table is in error in that FAHC is rated as "High" (meaning most likely to meet the standard) with respect to "Lowest Capital Construction Cost". Indeed, all the grades in the row marked "Lowest Capital Construction Cost" appear to be in error when compared with the cost estimates presented in the body of the application. Please review and explain.**

The Table is in error. Corrected Table is attached.(Attachment 24)

e. **Why is a "single program state run" rated "Low" in terms of "System design creates a 'critical mass'"?**

See definition for "critical mass" requiring the aggregation of both patients and resources to achieve program goals (Q 91 above).The single program does not advance an integrated model of care or achieve critical mass.

f. **Please explain the apparent inconsistency between the statements that the "schematic is presented without any attempt to weigh or assign values to the various dimensions" (p. 51) and that "As the Table indicates… Fletcher Allen Health Care and Rutland Regional Memorial Hospital present the best option…"**

The schematic presented does not provide quantitative values but supports a general qualitative finding based on "high," "medium," and "low" value assignments. Further quantitative analysis will be explored in Phase II.

g. **In light of the statement on page 52 that "Partner input has not yet occurred with respect to developing the cost estimates and potential operating savings associated with co-location", what are the cost criteria valuations included in Table 9 based on?**

Preliminary assessments only. More complete cost estimates and operational savings evaluations will be developed in Phase II.

104. **The application indicates (p. 52) that neither FAHC, RRMC, nor the Retreat have "agreed to any of the project cost estimates herein." Please indicate:**

a. **Whether FAHC, RRMC and/or the Retreat have reviewed and/or provided feedback on such cost estimates. If so, please provide the documentation.**

In the development of the preliminary cost estimates for construction, Fletcher Allen Health Care (FAHC) and Rutland Regional Medical Center (RRMC) both provided historical information regarding past experiences on previous construction/renovation projects of their campus. This information was provided verbally in the form of approximate costs per square foot. FAHC also provided input on the methodologies used for calculating overall project costs based on the per square foot construction costs. Both FAHC and RRMC were provided copies of the cost estimates. Attached are copies of the documentation surrounding this issue indicating the extent of input from these entities. Retreat Healthcare in Brattleboro has not provided any construction cost data nor have we compiled any formal cost estimates for this work.

See BGS attachments 1-104.a)-1 – 4(Attachment 37)

FAHC, RRMC and the Retreat have reviewed the preliminary cost estimates and have indicated that they have not agreed to any of these preliminary estimates. They have indicated their willingness to proceed once the conceptual CON has been granted.

b. **Whether FAHC, RRMC, and/or the Retreat have conducted, or caused to be conducted, project cost estimates. If so, please provide the documentation..**

To our knowledge, FAHC, RRMC and Retreat Healthcare have not performed, or caused to be performed any project cost estimates outside of the estimates provided by the State and their consultants.

105. **Regarding Construction Costs (p. 53, et.seq.):**

a. **What are the "various sites" Architecture Plus conducted preliminary assessments of?**

Multiple sites on the campus of FAHC were identified as potential locations for the new inpatient facilities. Attached is a site plan showing the identified sites; letters indicate the corresponding site as follows: See BGS attachment 1-105.a) (Submission Attachment 37)

A. East of the new Ambulatory Care Center
B. In the South Parking Lot
C. West of the new Ambulatory Care Center
D. Replacement of Smith/Patrick adjacent to McClure
E. Replacement of the McClure Parking Garage
F. On the so called Sliding Hill
G. On the site of the current State Health Lab.

b. **How, why, and by whom, were those sites selected?**

Any site that exhibited a potential to locate the new inpatient facility was selected. Representatives of FAHC, Architecture Plus with their consultants, and the State selected the sites jointly. The State Health Lab site was included to provide a comparison between an integrated facility and a stand-alone facility.

c. **Please provide all documents containing Architecture Plus' cost estimate information**

Attached are spreadsheets provided in the development of the project cost estimates. Note: The initial estimates were developed for a base 32-bed VSH replacement inpatient facility. The initial spreadsheets were revised to the proposed 40-bed base simply by taking the facility size in the 32-bed model dividing it by 32 to determine the area per bed and then multiplying by 40 to provide an approximate facility size for the 40-bed base facility. See BGS attachments 1-105.c)-1 – 3 (Submission Attachment 37)

d. **Please explain and document the "different methodologies" Architecture Plus used (see p. 53)**

The "different methodologies" referred to are basically a comparison of estimates provided by Architecture Plus independently, Marshall & Murray, Inc., an independent cost estimating firm, and Architecture Plus with input from FAHC. This information can be found in the attached project cost spreadsheets mentioned above.

e. **Please explain and document the "very limited input" Architecture plus received from FAHC and RRMC. Also, was any input received from the Retreat? Please explain.**

The "very limited input" received from FAHC and RRMC involved information provided on a construction cost per square foot based on their previous experience. Also refer to the response to question 104. a). No input was received from the Retreat.

f. **Why does the estimate for a 40 bed integrated facility at FAHC indicate it includes a cost for "replacement parking"? What parking will need to be replaced?**

In order to provide cost comparisons for the 40-bed and 68-bed integrated models, the estimates were developed for the same sites that we assumed would provide the greatest potential for integration. The estimate was developed for the McClure Garage site. Since parking is at a premium on the FAHC campus, replacement parking facilities would need to be included to avoid a negative impact on the FAHC operations

g. **Why is the cost estimate for the 40 bed integrated facility higher than the cost estimate for the 40 bed stand alone facility?**

The estimated cost for the 40-bed integrated facility in this case is higher than the cost for a 40-bed stand-alone facility because the mitigation of the impacts on FAHC infrastructure, services, and operations is included.

h. **Under the "68-bed integrated facility" model, what has been communicated by FAHC, or anyone else by or on behalf of FAHC,**

would become of the current FAHC inpatient psychiatric care facility?

To our knowledge, no information has been communicated between the State and FAHC or anyone else as to what would become of the current FAHC psychiatric inpatient space.

i. **Do the cost estimates presented include:**
   i. **Soft costs**
   ii. **Capitalized interest**
   iii. **Demolition costs**
   iv. **Relocation costs**
   v. **Backfill costs**
   vi. **Equipment**
   vii. **Furnishings**

The estimates presented include anticipated costs for construction, special conditions, site development and logistics, planning and construction contingencies, escalation, furniture, equipment, and special systems, and project soft costs.

106. **What cost estimates, if any, has VDH done, reviewed, or become aware of concerning the provision of such ancillary services as diagnostic, lab, laundry, food, or other needed facility services on each campus being considered? Please explain.**

FAHC indicated analysis of food services capacity and materials and storage capacities will need to be completed to determine their ability to accommodate the additional beds proposed. FAHC identified these ancillary services as at or near their limits. These studies and associated cost estimates have not been completed.

107. **Table 11 (p. 57), regarding projected bed need for adult mental health inpatient care, indicates there would be a decreasing need for SIP beds and general beds as implementation of community resources increases. It does not, however, indicate any change in the need for ICU beds. Please explain.**

Milliman assumed that required beds for specific levels of care would vary by scenario. See pages 49-50 of their report for their discussion of assumptions about levels of care (Appendix B of the August 17, 2006 CON Application).Given the ICU definitions, Milliman does not believe that implementation or non-implementation of Community resources will impact utilization of ICU beds. See Table VII 2 Page 49 and Tables VII-3 and Table VII-4, p.50. Community resources would, however, impact lower levels of care.

108. **The application indicates that a reason Dartmouth Hitchcock Medical Center is not an available resource to replace VSH bed capacity is because DHMC's patients are voluntary.**

a. **How is this relevant to future planning to replace VSH?**

See answer 13(c) above.

b. **Are FAHC, RRMC and the Retreat's current patients voluntary and/or involuntary? Please explain.**

FAHC, RRMC and the Retreat's current psychiatric patients are both voluntary and involuntary. As designated hospitals they are certified by the state to provide voluntary and involuntary services to people committed to the care and custody of the Commissioner of the Vermont Department of Health.

109. **The application indicates the project would create a bed capacity in 2012 that would range from 157 to 167 beds and "permit expansion-contraction as needed." (p. 57)**

a. **Please update the bed projection, and the data on Table 12, to reflect need through 2016**

This Table was constructed from available data. Updates will occur as part of Phase II planning.

b. **Please indicate how each of the project's inpatient components, as currently contemplated on the FAHC, RRMC, and Retreat campuses, could permit expansion, both in terms of facilities and programs. Please respond separately as to each campus.**

Further facility and program development will be developed in Phase II planning.

110. **Regarding Table 12 on page 58:**

a. **Are the psychiatric beds referenced licensed separately or distinctly from other beds in each of the hospitals listed? Please explain.**

Psychiatric beds are not licensed separately from other acute care licensed beds. They are a sub-set of licensed beds that are not, however, interchangeable with non-psychiatric acute care beds.

b. **Why are the Veterans Administration beds projected to decrease in number?**

We do not have this information. The data in Table 12 was drawn, in part, from the HRAP, Chapter 1, Page 40 Current Supply and Distribution. The BISHCA staff note

citing the source of the data indicates it was obtained through interviews with staff from the VA Hospital and Dartmouth-Hitchcock Medical Center.

c. **Why are the CVH, FAHC, RRMC, Retreat, and DHMC beds not projected to increase in numbers over a ten year period except for a one-for-one replacement factor to accommodate for the closing of VSH?**

As noted in (b) above the data in Table 12 was drawn, in part from the HRAP. Projections for DHMC are based on the HRAP data. The projections about future inpatient increases for the other hospitals are based on 10 year trend data indicating a general overall downward trend for inpatient hospitalizations in Vermont. (See Table 6, p. 43 and Graph 5, p. 44 of the August 17, 2006 CON Application). This is consistent with increasing use of alternatives to general psychiatric inpatient hospitalization, such as intensive outpatient programs, enhanced care management and improved psychotrophic medications. The table also reflects the assumption that general psychiatric hospital inpatient populations do not require the same level of service intensity as the VSH population.

111. **What role does the Veterans Administration hospital (VA) inpatient psychiatric unit play in the continuum of care available to Vermonters with serious mental illness and how do the VA and VDH coordinate such care?**

The VA provides mental health services, both inpatient and outpatient services, to veterans and in some instances their families. The VA does not provide involuntary inpatient care at their hospital in White River Junction. VSH coordinates care with the VA through typical case coordination mechanisms including case consultation.

112. **In preparation for replacing or improving VSH, has VDH obtained any information regarding how other states, both in terms of facilities and programs, serve their patient populations most similar in need to the patients at VSH? If so, please explain and provide supporting documentation.**

We have had preliminary informal communication about the experience of other states through the National Association of State Mental Health Program Directors.

113. **The application indicates that "As an isolated, stand alone unit VSH cannot meet the quality standards for best practices for mental health service delivery." (p. 60).**

a. **Is it VDH's conclusion that it is impossible for isolated, stand alone units to meet quality standards for best practices for mental health service delivery? Please explain.**

We do not believe that best practices standard can be met when psychiatric inpatient care is separated from other types of inpatient care. We don't believe it can be met currently nor will it be met in the future as the treatment and technology for severe mental illness

continue to evolve. There are essentially 3 arguments for clinical integration of psychiatric and other medical inpatient care: (1) the high proportion of co-morbidity and mortality among inpatient psychiatric patients; (2) the changing nature of relevant neurological, biological and psychiatric knowledge for treatment; (3) the access barrier to timely and adequate diagnosis and treatment of physical health conditions of psychiatric patients created by housing psychiatric patients in separate institutional settings.

Recent literature supports these claims. See, for example: Roy-Byrne, Peter, MD, "Untreated Medical Co-morbidity Is High in Patients with Serious Mental Illness," *Journal Watch Psychiatry*, August 7, 2002; Dickey, B., et al (Jul 2002)/ Medical Morbidity, Mental Illness and Substance Use Disorders," *Psychiatric Services*, 53:861-7; Bartels, S., MD (Dec 2004). "Caring for the Whole Person: Integrated Health Care for Older Adults with Severe Mental Illness and Medical Co-morbidity," *JAGS*, 52, 12: S249-S257; Price, B.,MD, Adams, R., MD, & Coyle, J.,MD (Jan 2000). *Neurology*, 54: 8-14; Martin, J., MD, Ph.D. (May 2002). "The Integration of Neurology, Psychiatry, and Neuroscience in the 21st Century, *American Journal of Psychiatry*, 159: 695-704. Horvitz-Lennon, M., Kilbourne, A., & Pincus, H. (May/Jun 2006). (Attachment 26) See also "From Silos to Bridges: Meeting the General Health Care Need of Adults with Severe Mental Illnesses," *Health Affairs*, 25, 3:659-669 (Attachment 2).

Recent point-in-time data illustrates the level of co-morbidity found among VSH inpatients in 1999, 2000, and 2002.

Severity of Medical Illness at Vermont State Hospital
Point in Time Data, 1999 - 2002

	8/11/1999 # Patients	**8/11/1999 % Patients**	**8/25/2000 # Patients**	**8/25/2000 % Patients**	**5/27/2002 #Patients**	**5/27/2002 %Patients**
Bed Census	47		42		49	
Severity Level*						
No Axis III Dx	3	6%	4	10%	5	10%
Health Issues	21	45%	14	33%	18	37%
Serious	16	34%	15	38%	17	35%
High Risk	7	15%	9	21%	7	14%
Total Patients with Significant Health Burden	**23**	**49%**	**24**	**59%**	**24**	**49%**

*Definitions: "No Axis III Dx" = no diagnosed non-psychiatric health conditions. "Health Issues" = medical or health conditions requiring assessment & treatment but without complications or high risk to patient, e.g., obesity without complications, healing wounds, fungal infections of skin, nails, etc. "Serious Conditions" = medical conditions that have life threatening potential, may be chronic, and require on-going treatment to maintain functioning or prevent or delay deterioration or death. "High Risk Conditions" = are

those that have the potential for sudden deterioration requiring emergent treatment at any time due to end stage disease, unstable health condition.

b. **Is VDH aware of any isolated, stand alone units that currently meet quality standards for best practices for mental health service delivery? Please explain.**

VDH is aware that there are stand alone state run psychiatric hospitals that meet CMS accreditation standards.

c. **Please provide source information and documentation of the referenced quality standards for best practices.**

See response to Questions 1, 10, and 42 above, also Question 116 below.

114. **What is meant by "a public/private partnership between the State of Vermont and three of Vermont's private general hospitals."? Please outline the rights and responsibilities of the parties under the partnership.**

The phrase "public/private partnership" as used here is a general phrase to describe the various ways that the state and the three identified hospitals, FAHC, RRMC and the Retreat, work together to meet the in-patient mental health needs of Vermont residents. Each of these three hospitals is also currently a hospital designated by the Commissioner to provide involuntary care to people committed to the care and custody of the Commissioner of the Vermont Department of Health. The process for Commissioner designation is outlined below in the answer to Question 115.
Whether and how the current designation process will change, and what the rights and responsibilities of the parties will be at the primary and secondary VSH replacement facilities is subject to further research, planning and negotiation.

115. **Please describe the current legal and management relationships, including rights and responsibilities, between the Designated Hospitals and the State. How does VDH "ensure that clients' rights are protected, that the custodial role of the state is appropriately carried out" and that "clear and enforceable contracts with service providers are developed and maintained"? (p. 68)**

Hospitals that provide involuntary psychiatric inpatient care must be designated by the Commissioner of Health based on specific standards, policies and procedures that demonstrate adherence to Vermont Statutes and enable adequate oversight by DMH. These hospitals are reviewed annually for re-designation purposes.

116. **How will co-location of inpatient psychiatric beds at FAHC enhance "exploration and testing of new ways for other health professionals to serve individuals with severe and persistent mental illness and co-occurring disorders" in ways not possible currently pursuant to the contract FAHC has with VDH to supply psychiatric health care professional services to VSH? (p. 62)**

The presence of other disciplines on the Fletcher Allen Health Care campus creates opportunities that would not be available to a distant site for which Fletcher Allen Health Care provides only psychiatrists. Innovations developed in nursing, physical therapy, or other medical disciplines can be more easily applied to inpatient psychiatry when investigators are close by and part of the same administrative system. These opportunities will arise out of the creativity of clinical investigators and leaders of clinical programs in ways that we may not be able to anticipate. For example, Alan Rubin, M.D. conducted a rigorous study of his protocol for internist involvement in the care of psychiatric inpatients at Fletcher Allen Health Care. His published results showed that twelve of seventeen processes of care improved significantly under his protocol, without increasing overall cost or length of stay[21].(Attachment 27) This kind of study improves patient care, integrates psychiatry with other disciplines, models quality improvement, expands our knowledge of clinical care, and helps attract and retain excellent staff.

117. **Similarly, how will co-location of inpatient psychiatric beds at FAHC enhance "education and training opportunities for an array of health and mental health professionals" in ways not possible currently pursuant to the contract FAHC has with VDH to supply psychiatric health care professional services to VSH?**

The Fletcher Allen Health Care campus is the major teaching site for residents in psychiatry and other disciplines of medicine, as well as for medical students at the UVM College of Medicine. In addition, the university hosts training programs in other health care professions, including nursing, advanced practice nursing in psychiatry, psychology practicum students, post-doctoral students in psychology, and other biomedical departments. Co-location will provide practical opportunities for these trainees to participate in a multi-disciplinary inpatient psychiatry team. The current contract between VSH and FAHC is limited to attending psychiatrist participation, and limited participation by psychiatry residents.

118. **How will the project help alleviate the identified (p.63) shortage of adult and pediatric psychiatrists?**

During the early years of medical school training, medical students are exposed to many disciplines within medicine. This occurs formally and informally over a period of several

[21] A. Rubin (April 2005). "Effects on Processes and Costs of Care associated with the Addition of an Internist to an Inpatient Psychiatry Team," Psychiatric Services 56:463-467 Available online: http://www.psychservices.psychiatryonline.org/cgi/content/full/56/4/463

years. The segregation of inpatient psychiatry implies for students that psychiatry is unlike other disciplines in medicine and is less worthy of their consideration. Furthermore, segregation makes it difficult for them to meet patients and be exposed to intensive psychiatric services. It is our hope that increasing the visibility of psychiatry and psychiatrists, and increasing the interaction between faculty psychiatrists and students, will help to interest students in postgraduate training in psychiatry. Many trainees pursue subspecialty training in geriatric psychiatry and child psychiatry, and a larger pool of trainees will yield more psychiatrists with subspecialty expertise. A healthy and attractive inpatient psychiatry system in Vermont will help motivate graduates of psychiatry residencies to return to Vermont to work in our hospital units.

119. **Please elaborate on the project's interaction with and relationship to the Vermont Blueprint for Health (Blueprint), the Chronic Care Model (CCM), the Futures Care Management (FCM) System (all referenced in the application), and the Vermont Information Technology Leaders (VITL).**

The Blueprint for Health, the Chronic Care Model, VITL and the Futures Project are all VDH projects proceeding on parallel tracks and led by VDH. Ultimately it is the same management team responsible for all these projects. As planning develops we will create structural cross-over and integrated implementation.

120. **Please explain how the project's components will integrate or be integrated and compatible with the Blueprint, CCM, FCM, VITL, and each hospital's existing and/or planned systems regarding:**

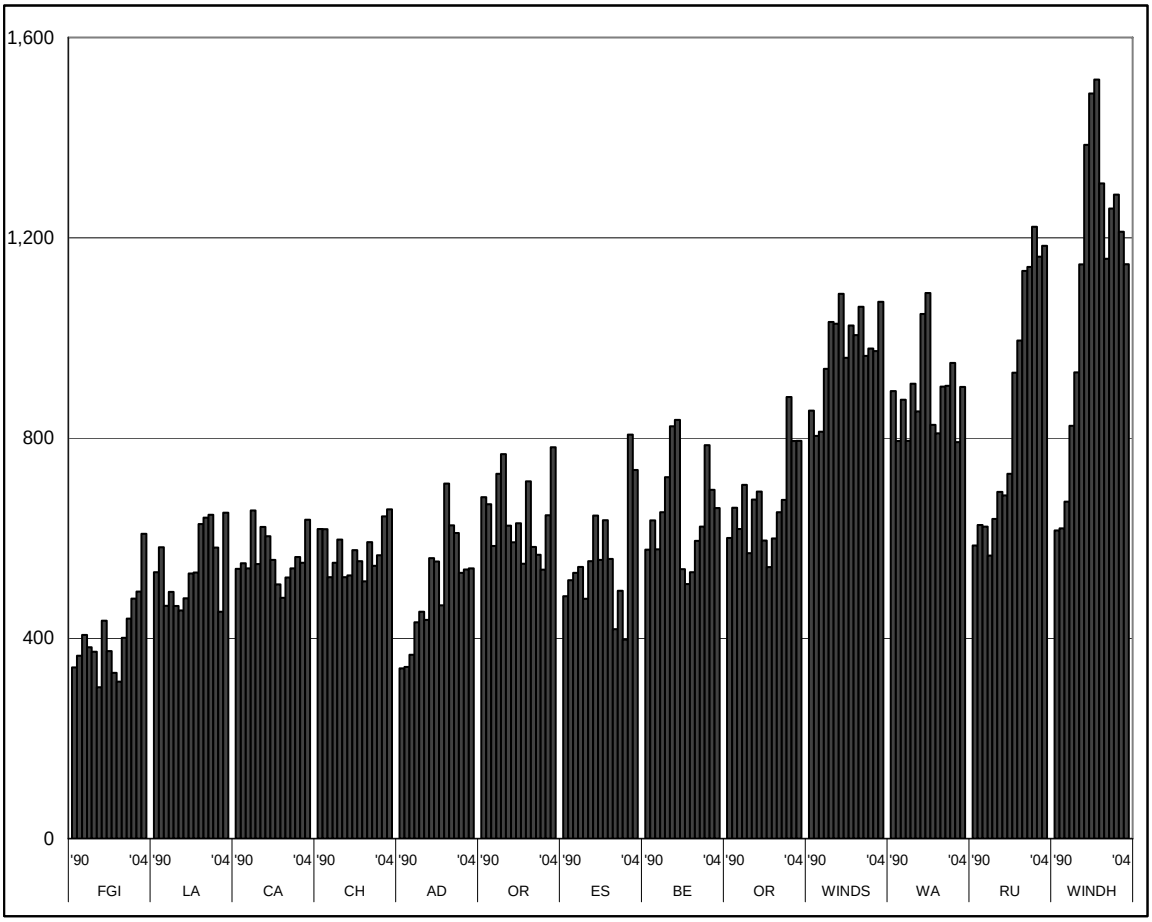
See the response to Q 119 above. It is VDH's expectation that as the Futures Project proceeds the partner hospitals will integrate (a) through (i) with the Blueprint, CCM, FCM, and VITL, as part of the on-going hospital implementation processes. Planning will proceed under Phase II.

a. Clinical information, including but not limited to patient health records
b. Care management
c. Management systems
d. Financial systems, including but not limited to billing
e. Quality measures, both process and outcome based
f. Accreditation
g. Compliance
h. Privacy
i. Quality improvement

121. Please provide a replacement of Table 14 prepared and reproduced in such as way as to facilitate review.

Please see replacement Table 14 below.

Episodes of Hospitalization Per 100,000 Population
for Behavioral Health Care, Vermont Residents: 1990 - 2004



Episodes per 100,000 Population by County of Residence

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Total	619	619	598	639	679	680	740	728	709	720	752	748	782	768	814
Franklin/Grand Isle	342	365	407	382	373	302	435	375	331	314	401	439	479	493	609
Lamoille	532	582	465	493	465	456	480	529	531	628	641	647	581	453	651
Caledonia	539	550	540	655	549	623	604	557	508	481	522	540	562	551	637
Chittenden	619	618	522	551	598	522	526	576	554	514	592	545	566	644	658
Addison	340	343	367	432	453	437	560	554	466	709	625	610	531	538	540
Orleans	682	668	584	729	768	625	592	630	549	714	582	567	537	646	782
Essex	484	516	531	543	479	554	645	557	636	559	418	495	397	807	736
Bennington	577	635	578	652	722	824	836	538	508	532	595	623	786	697	660
Orange	600	661	618	706	570	677	693	595	542	600	652	676	882	794	795
Windsor	855	805	813	938	1,032	1,028	1,088	960	1,025	1,006	1,062	964	979	974	1,072
Washington	894	794	876	795	908	854	1,048	1,090	827	809	903	904	950	792	902
Rutland	586	626	623	565	639	692	686	729	931	995	1,134	1,142	1,222	1,162	1,184
Windham	616	620	673	825	931	1,147	1,386	1,488	1,516	1,309	1,158	1,259	1,286	1,212	1,147

Information is derived from the Hospital Discharge Data Set maintained by the Vemont Health Department, and database extracts provided by the Brattleboro Retreat and Vermont State Hospital. Behavioral health care includes both mental illness and substance abuse.

122. **Regarding the sustainability of "Designated Agenc[ies]" referenced on page 69 and the five programs cited, please clarify whether the Designated Hospitals are considered Designated Agencies. Please explain.**

Designated Hospitals (DH's) are not considered Designated Agencies (DA's). The designation status refers to designation by the Commission of Health to provide specific services according to VDH statutory powers. DH are designated to provide involuntary inpatient treatment to people who are in the care and custody of the Health Commissioner. DA refers to the powers of the Commissioner to identify those agencies authorized to provide comprehensive community mental health and developmental services.

123. **One of the responses to the Request for Information (appendix A), the response from the Northeast/Central Collaborative, (hereinafter the NCC), consisting of The Clara Martin Center, Northeast Kingdom Human Services and Washington County Mental Health Services, particularly proposed resources to address needs in the central and northeastern part of Vermont, regions it appears are addressed in the application less directly by the proposed plan than are the northern and southern regions of the state. The NCC also indicated a history of working collectively with Central Vermont Hospital, Gifford Hospital, Northeastern Vermont Regional Hospital, the Dartmouth Hitchcock Alliance and the Veterans Administration Hospital, facilities serving the central and northeastern regions of Vermont. Given that FAHC, RRMC and the Retreat are generally identified as serving the northern and southern regions of the state, please describe any follow-up the State has conducted with the NCC or its members or the referenced hospitals to further meet the needs in central and northeastern Vermont.**

The state did follow up with efforts to locate a community residential recovery program at the sub acute level of care in Greensboro. These initial efforts were not successful and other program development is in progress with North East Kingdom Human Services.

124. **The response by the Howard Center for Human Services (the Howard) to the RFI echoed concerns expressed in the NCC response regarding past failures by the State to fund community-based programs designed to help move services from more institutional settings. What is VDH's response to these concerns?**

The Futures Plan and the allocation supported by the Legislature includes funding for new community administrated programs. Secondly, AHS second sustainability study is designed to develop identify and quantify these needs and to develop recommendations for how these can be addressed.

125. **Does VDH agree with the following assertions in the Howard's response to the RFI? Where questions are included within the quoted text please respond to those questions:**

a. **"minimum VSH hospital based bed capacity must be maintained at no less than the current levels. Though step-down and sub-acute**

services expansion as well as enhanced peer services models, over time, may demonstrate an ability to reduce such capacity, it would be premature in the planning stage to construct a service model on an unproven assumption."

We believe that we understand the nature of the concern that is being raised here. The current plan for 50 inpatient beds is at least partly responsive to this concern. We will further evaluate these assumptions in Phase II.

b. **"Our experience …would suggest that significant change will be necessary in order to actualize an efficient system that is not confronted with patients in need of voluntary or involuntary admission and bed-based providers unwilling to accept them."**

We are aware of this issue and the developing care management system will be designed to address this.

c. **"…the RFI …appears to represent a significant expansion (with regard to TBI, DD and, to some extent, trauma) of populations currently served at VSH." "…adults with SPMI are funded through the Medicaid Waiver Case rate system, while clients in the DD population are served on an individual waiver basis. Will the change in modeling capacity necessitate changes in either or both waiver models? Will funding for all clients/patients be consistent across diagnostic categories?"**

These populations are currently served at VSH. There is no intent to expand the populations served.

d. **"Any change in the location of VSH beds will no doubt exacerbate an already critical problem in housing in the Burlington area. Supervised apartments, shared-living arrangements, group homes, transitional housing and community care homes are all inadequate to meet the current need and contribute, in no small part, to the 'back-up' in the movement of clients throughout the system. Any transformed system must address this end of the service spectrum with the same vigor as acute bed access."**

The Futures Project understands the need for more affordable housing in all of Vermont's communities including the Burlington area. The original plan calls for modest amount of resources for new housing. There is a work group currently exploring this issue.

126. **The response by the Retreat to the RFI proposed adding a 16 bed acute care unit that could serve 10 general psychiatric acute care patients and six patients in need of psychiatric intensive care. The Retreat also**

indicated this unit could flex between the two needs. Why does the project as proposed only plan on adding 4 beds at the Retreat, none of which would be at the intensive care level?

The RFI was conducted early on in the planning process and was simply a statement of interest. These initial proposals have been amended as the plan became more developed.

127. **The response by FAHC to the RFI proposed the "managing and/or staffing of a state-owned inpatient psychiatric facility…constructed and operated with state funding." Why does the project as proposed not plan for the facility at the FAHC campus to be state-owned?**

The ownership status of the proposed facility on the FAHC campus has yet to be determined and requires more research, planning and negotiation.

128. **The application states that the options ("preferred options, p. 2") being presented "are the result of multi-stakeholder study and input," (p. 1) and that the plan "has been developed by a multi-stakeholder advisory committee that has met for over two years." Please identify and attach any specific portions (in sufficient context) of minutes, or motions and recorded votes, of any multi-stakeholder group, the Futures group, or a Futures work group which provides input regarding, or proposes development of:**

a. **a "preferred option" of a program operating under the license of Fletcher Allen Health Care (FAHC)**

The Futures Advisory Committee Inpatient Work Group did the primary work in this area. See Attachment 28 for:

- The charge to the group
- The membership of the group
- The recommendation regarding creating a primary program site (September 20)
- Minutes from the Inpatient Work Group meeting November 1, 2005.
- Minutes from the full Futures Advisory Committee meeting on November 16th in which the inpatient partner site and selection criteria were finalized.

b. **an addition of licensed beds at the Rutland Regional Medical Center (RRMC)**
c. **renovation and/or expansion of the psychiatric programs at RRMC**
d. **renovation and/or expansion of the psychiatric programs at Retreat Healthcare (Retreat)**

Based on the conclusions of the inpatient work group and the advisory committee, Futures Project Director Beth Tanzman requested that Retreat Healthcare and Rutland Regional Medical Center express their interest in writing and to also confirm that they

understood the site and partner selection criteria. Attached are the letters sent by RRMC and Retreat Healthcare.(Attachment 29)

Beginning in January 2006 VDH created a facilities work group including Frank Pitts, BGS consulting architect working with RRMC, FAHC, Retreat and members of the Futures Committee to develop the "initial program of space" for the primary and secondary inpatient services.

Attached are the following documents from the Facilities Work Group that contain information about the developing concepts of smaller inpatient capacities or secondary sites at Retreat Healthcare and Rutland Regional Medical Center.(Attachment 30)

- Futures Facilities Work Group membership list
- December 20, 2005 scope of work meeting for Architecture Plus
- January 28, 2006 summary of a work meeting with Architecture Plus
- February 03, 2006 first program of space design for RRMC (shared with facilities work group)
- February 6th meeting summary of Facilities work group with reference to the secondary or smaller capacities
- February 13, 2006 second draft program of space for both primary and secondary (smaller) capacities.
- February 21, 2006 meeting summary of the Facilities work group with reference to the secondary or smaller capacities
- May 22, 2006 power point presentation to the Facilities work group – excerpts of those slides relating to smaller or secondary capacities.

129. **The application states that the Futures Advisory group "strongly endorsed" the recommendations of the Inpatient Work Group regarding primary and secondary inpatient partner criteria, and that these recommendations were accepted by then-Secretary of the Agency of Human Services, Michael Smith (pg.7). Please supply the minutes and the motion(s) as voted on by the Futures Committee, specifically including any changes or additions made from the recommendations forwarded by the Inpatient Work Group.**

See answer to Question 128 a for minutes of the Inpatient Work Group and Advisory Committee meetings.(Attachment 28)

In addition, please provide documentation regarding the recommendations that were accepted by Secretary Smith.

Secretary Smith accepted and endorsed the recommendations.

a. **Please describe and explain any subsequent actions, including modifications, by the Agency of Human Services regarding such endorsement of these recommended criteria and conditions.**

The Futures Advisory Committee at their February 24, 2006 meeting narrowly passed a motion encouraging the Secretary of Human Services to "explore other options". The context was for options other than with FAHC on the Burlington campus. Based on this and other stakeholders opinions, the Vermont Department of Health included an "off campus option" in the application for a planning CON.

b. **Please describe and explain the ways in which the three hospitals identified under the "preferred options" have been assessed and demonstrated to meet each of the criteria. Please include a matrix setting forth all of the criteria and indicating to what extent each of the three hospitals meets each criterion.**

The only in-state hospital that could meet the criteria established for the primary program is Fletcher Allen Healthcare. The demonstration of how each proposed partner meets the full criteria will be addressed in the planning phase prior to applying for a Phase II CON.

130. **The application references the settlement with the Department of Justice (DOJ) as part of the current issues affecting the Vermont State Hospital.**

a. **Please file copies of the DOJ complaint as filed in federal court, all findings, and the settlement agreement.**

See Attachment 31.
During the course of negotiating the settlement agreement, the Department of Justice was fully aware of the Future's plan, specifically the plan to relocate inpatient psychiatric services and to close VSH.

However, regardless of the Future's Plan and the outcome of this CON application, the State of Vermont has agreed to a four year timeline within which to make the necessary changes at VSH and address each of the areas of concern listed below.

b. **Please file the memorandum provided by Wendy Beinner, Esq. to the Mental Health Oversight Committee on August 17th, 2006 regarding the "Terms of Agreement between the United States Dept. of Justice and the State of Vermont and please:**

Please refer to the settlement agreement and question 130(a).(Attachment 31) The settlement agreement details how the areas of concern listed below will be addressed by VSH at the current facility.

i. **specifically explain how the following health care issues identified in that document would be resolved by granting permission for VDH to replace the Vermont State Hospital:**

1. **integrated treatment planning**
2. **mental health assessments,**

3. **discharge planning and community integration,**
4. **monitoring of specific treatment services for safety, effectiveness, and appropriateness, particularly use of psychotropic medications,**
5. **documentation,**
6. **use of restraints, seclusion and emergency involuntary psychotropic medications,**
7. **protection from harm,**
8. **incident management,**
9. **quality improvement, and**
10. **identification, of environmental safety hazards, including potential suicide hazards; and screening of contraband.**

ii. **specifically explain how the following health care issues identified in that document can be resolved in the current Vermont State Hospital. If VDH contends it is impossible to resolve any or all of these issues in the current Vermont State Hospital please explain, specifically:**

1. **integrated treatment planning,**
2. **mental health assessments,**
3. **discharge planning and community integration,**
4. **monitoring of specific treatment services for safety, effectiveness, and appropriateness, particularly use of psychotropic medications,**
5. **documentation,**
6. **use of restraints, seclusion and emergency involuntary psychotropic medications,**
7. **protection from harm,**
8. **incident management,**
9. **quality improvement, and**
10. **identification, of environmental safety hazards, including potential suicide hazards; and screening of contraband.**

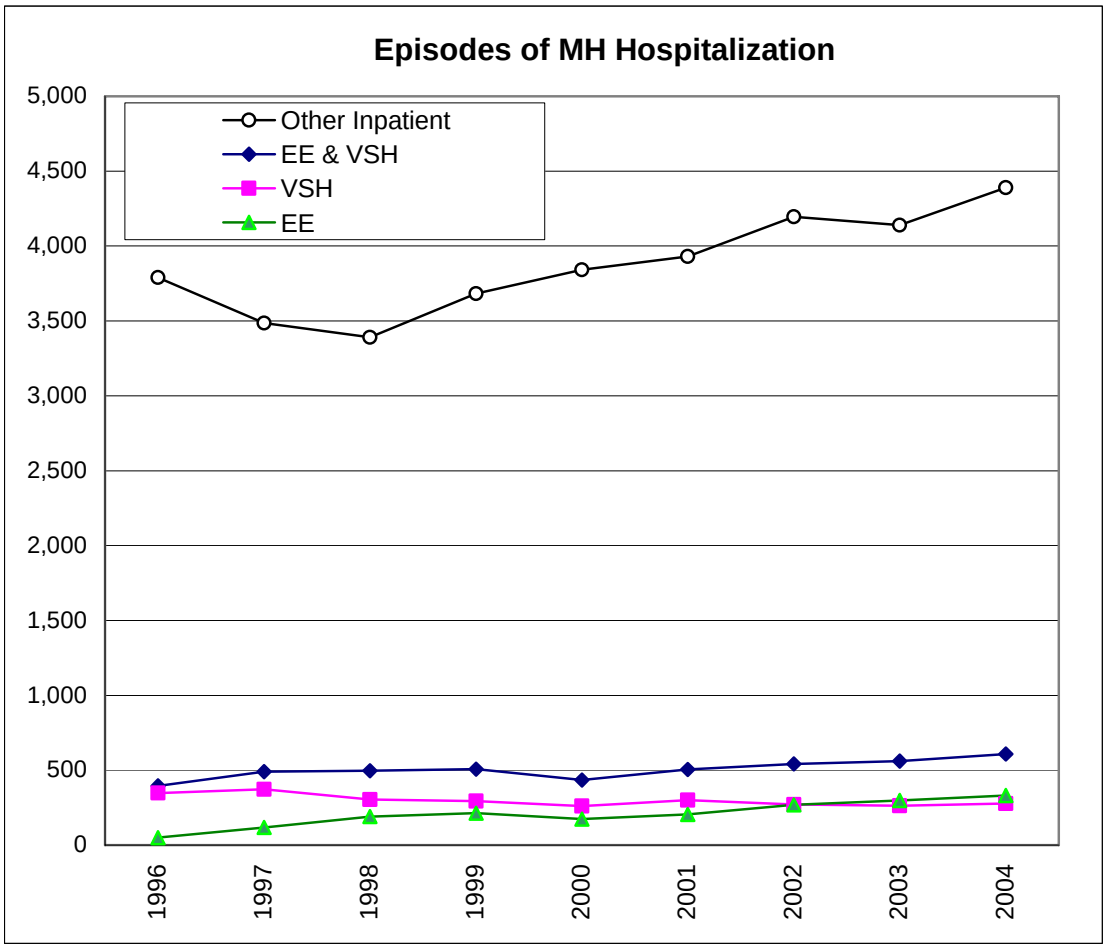
131. **The application at various times references the mental health service system, and the public mental health services system. (See, e.g., p.10) Please explain the distinction that results in a person being served by one system or the other, specifically including inpatient care, and explain why an individual is served at VSH or a "designated hospital" under the care and custody of**

the Commissioner, in comparison with other persons who are also admitted to general psychiatric units in the state's "designated hospital" network.

The mental health system includes both public and privately funded services. The public system refers to those services that are publicly funded. Any Vermonter may seek services from either system. The core distinction raised in this question is that individuals admitted for involuntary care are in the care and custody of the Commissioner. This is a matter or legal status, not site of treatment.

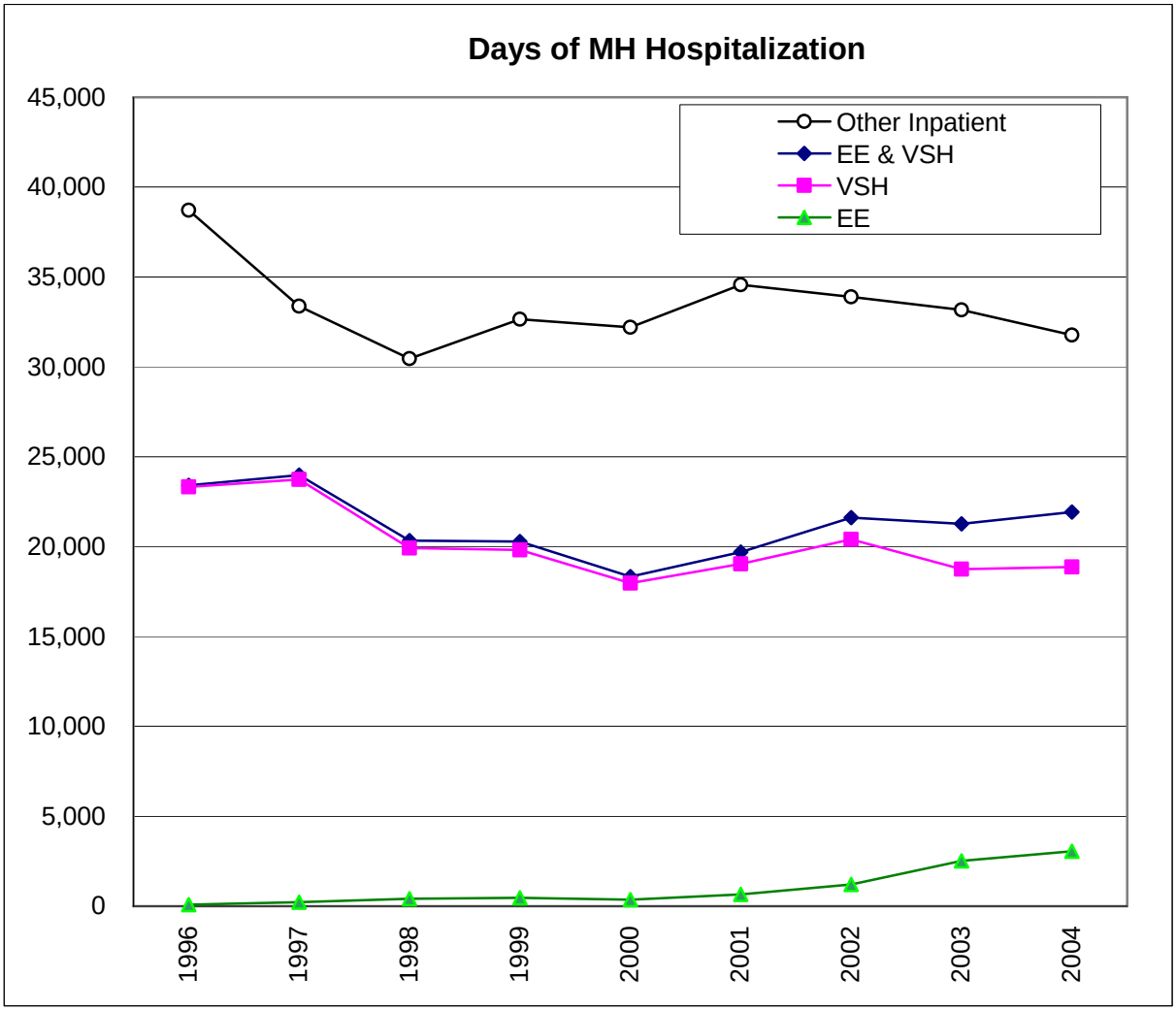
132. **Based upon the answer to question 132 above, how do the tables for per capita use of inpatient psychiatric care (pp. 13-15) relate to the forecast in need for capacity for patients currently served at VSH? Please supply data that contrasts the episodes of hospitalization, the patient days, and the unduplicated number of people served for all inpatient care provided to Vermont residents over the past 5 years with the same data for persons being served under the custody of the Commissioner (whether at VSH *or* at a designated hospital.) How do the rates of growth of each of these groups relate to the rates of the growth in population?**

See Tables below: (1) "Episodes of Mental Health Hospitalization", (2) "Days of Mental Health Hospitalization", (3) "People Hospitalized for Mental Health". Further Phase II analysis would be required to compare these utilization rates to the rates of growth in the general population.



Number of Inpatient Episodes

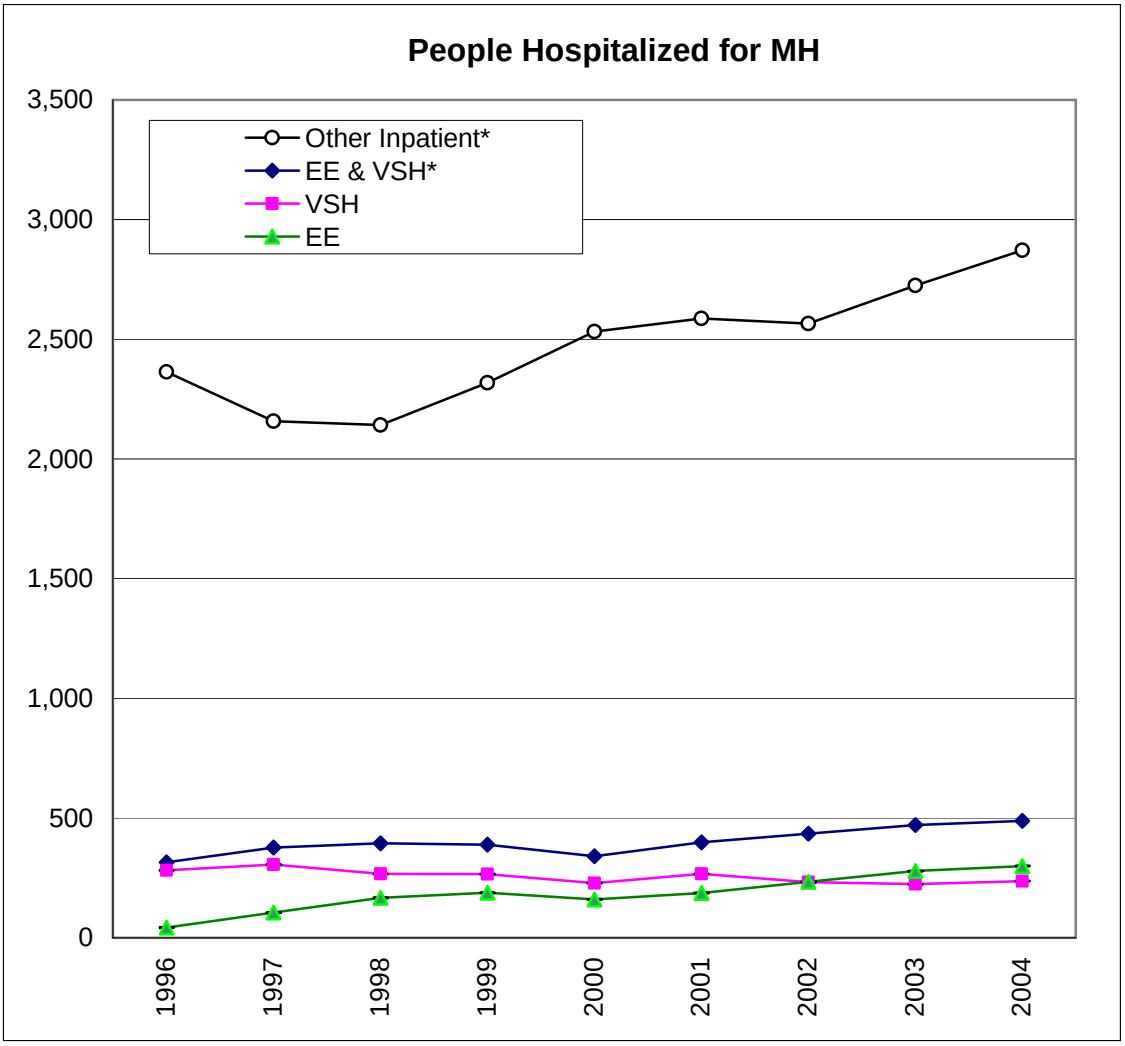
	1996	1997	1998	1999	2000	2001	2002	2003	2004
EE	49	118	191	214	173	204	269	298	332
VSH	347	372	305	293	261	300	272	263	277
EE & VSH	396	490	496	507	434	504	541	561	609
Other Inpatient	3,789	3,485	3,391	3,683	3,842	3,931	4,196	4,140	4,389
Total Inpatient	4,185	3,975	3,887	4,190	4,276	4,435	4,737	4,701	4,998



Days of Inpatient Hospitalization By Calendar Year

	1996	1997	1998	1999	2000	2001	2002	2003	2004
EE	86	232	417	459	369	660	1215	2522	3059
VSH	23,324	23,743	19,923	19,815	17,963	19,039	20,394	18,745	18,866
EE & VSH	23,410	23,975	20,340	20,274	18,332	19,699	21,609	21,267	21,925
Other Inpatient	38,713	33,367	30,455	32,647	32,202	34,563	33,892	33,162	31,768
Total Inpatient	62,123	57,342	50,795	52,921	50,534	54,262	55,501	54,429	53,693

Days for EE could not be calculated for 22 people because of missing end dates.



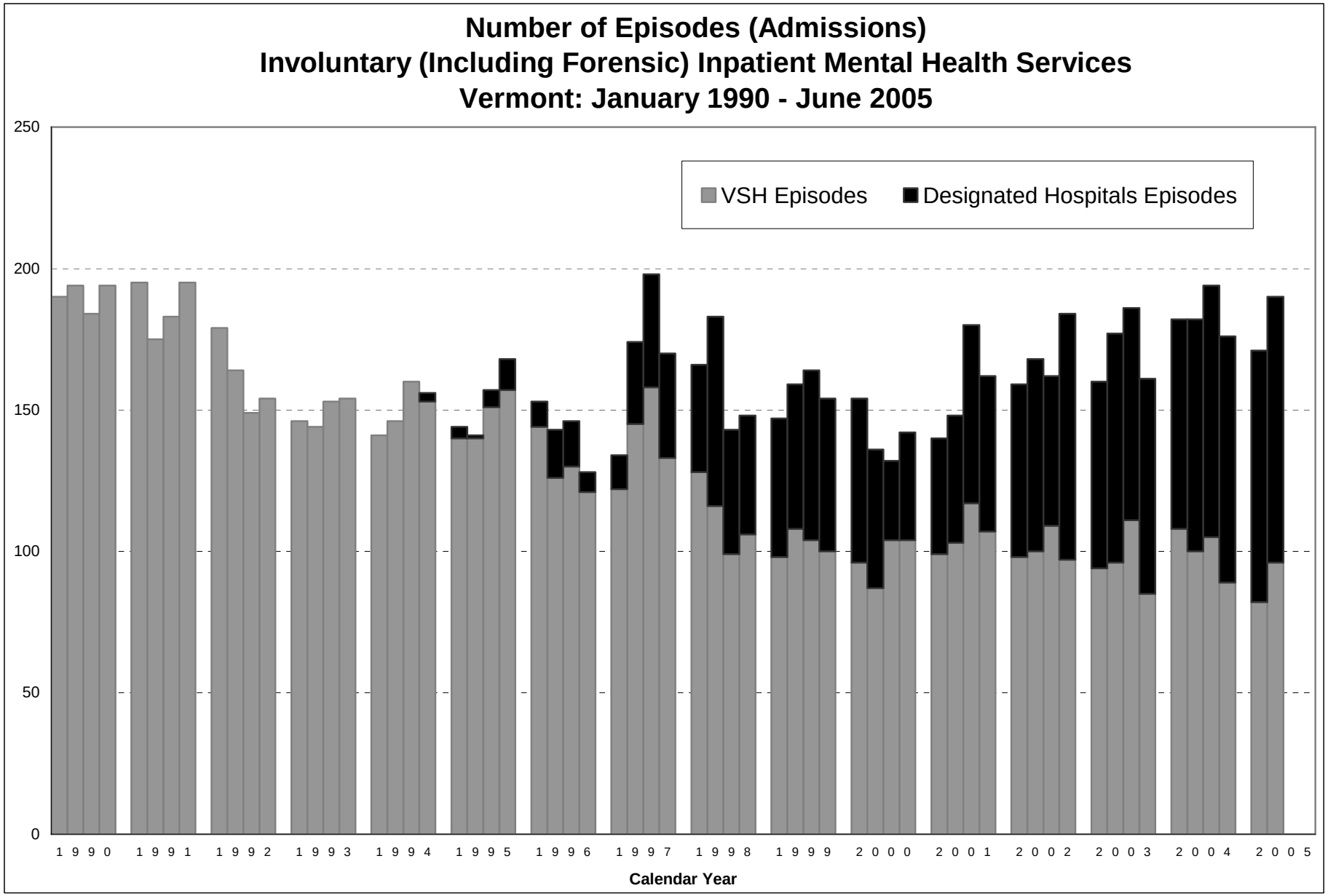
People Hospitalized for Mental Health

	1996	1997	1998	1999	2000	2001	2002	2003	2004
EE	43	105	167	188	161	187	234	279	300
VSH	282	306	267	266	229	267	232	224	237
EE & VSH*	315	377	395	389	341	398	434	470	488
Other Inpatient*	2,363	2,158	2,142	2,318	2,532	2,587	2,566	2,724	2,872
Total Inpatient*	2,688	2,569	2,576	2,772	2,922	3,041	3,032	3,227	3,409

* Because these anonymous extracts do not contain unique person identifiers, Probabilistic Population Estimation was used to provide unduplicated counts of people in each data set and the unduplicated number of people shared across the data sets.

133. On page 11, the application states that partnership with designated hospitals has resulted in a "significant shift in the number of involuntary admissions away from VSH." Please provide the data showing the outcomes of this shift, and how VSH bed use has changed if the census has remained stable despite this shift in admissions.

See chart below, "Number of Episodes (Admissions) Involuntary (Including Forensic) Inpatient Mental Health Services Vermont: January 1990 – June 2005"**.**



Includes both civil and criminal involuntary hospitalization at the Vermont State Hospital and other designated hospitals.

134. **Does VDH have any data to indicate why utilization of VSH has "been consistent for the past ten years" (page 17)? For example, is it because the need for its services has remained level, because the facility has been consistently close to capacity and other hospitals have been utilized to provide services that used to be provided at VSH, or because community programs have re-directed care from inpatient to outpatient? Please provide any and all data that support your conclusions.**

We do not have additional specific quantitative information to answer this question; it is likely that VSH utilization has remained level due to a combination of all the above listed factors.

135. **The application states that Rutland is licensed for 19 beds, but has an actual capacity of "10-12." The application also provides information about capacity, both psychiatric and non-psychiatric, at VSH and other hospitals. The information is not consistently presented, however, so as to compare among licensed beds, staffed beds, beds dedicated to psychiatric care, and beds dedicated to non-psychiatric care. Please revise the tables (see, e.g. table 4 on page 37) and/or create new tables, to clearly indicate and compare the numbers of *licensed* and the number of *staffed* beds for psychiatric and non-psychiatric care at all of the hospitals referenced, including Vermont State Hospital. Likewise, please review the fourth paragraph on page 37 and explain the connection between the references to "total acute care staffed beds" and the "total licensed acute care beds" contained therein.**

The data on which the August 17, 2006 CON Application was based was drawn from several sources and is the best that is currently available. Table 4, p.37 is based on HRAP data created by BISHCA. We do not have access to the original HRAP data. The categories of licensed and staffed beds are descriptions drawn from BISHCA and HRAP.

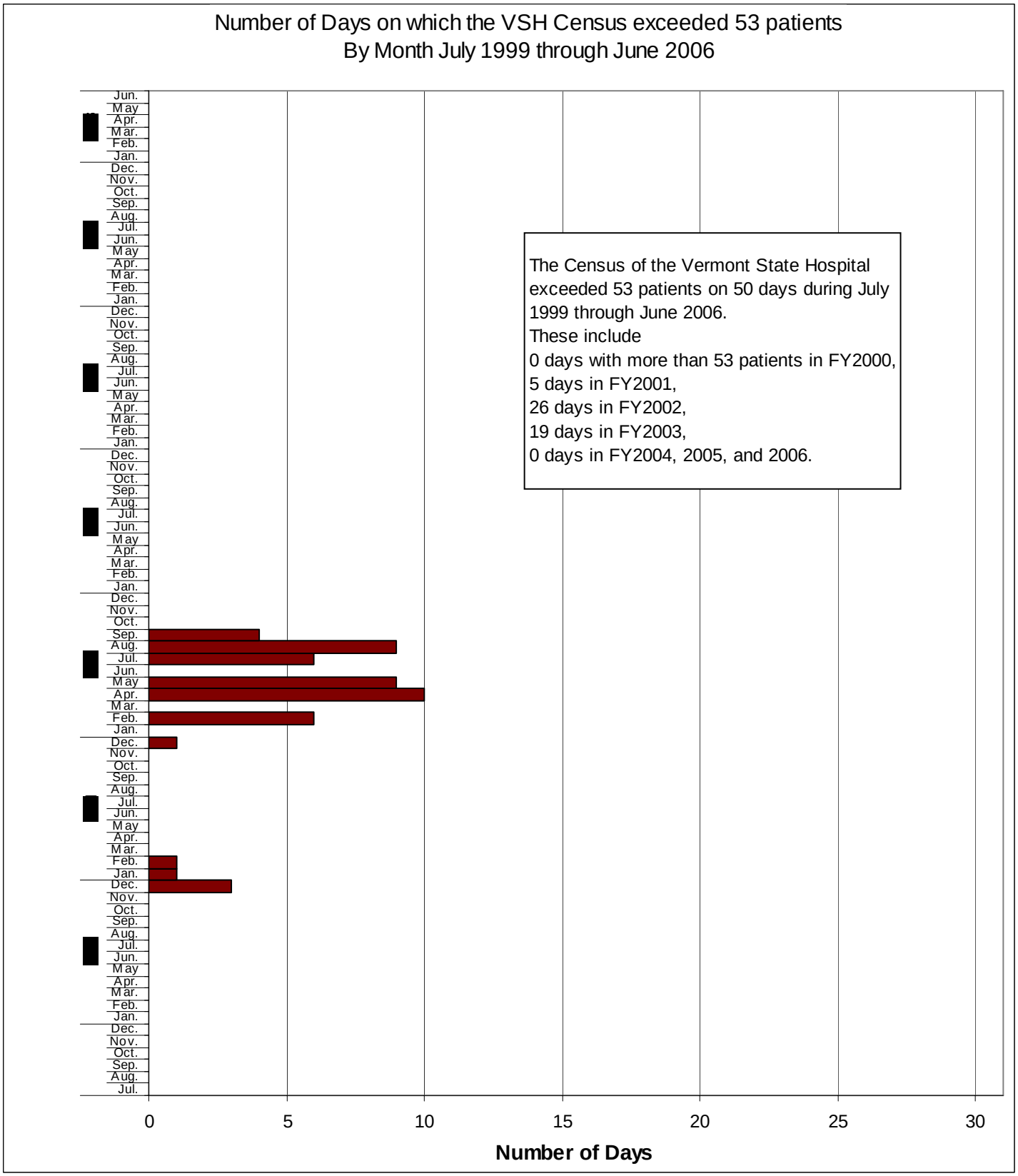
136. With respect to VSH:

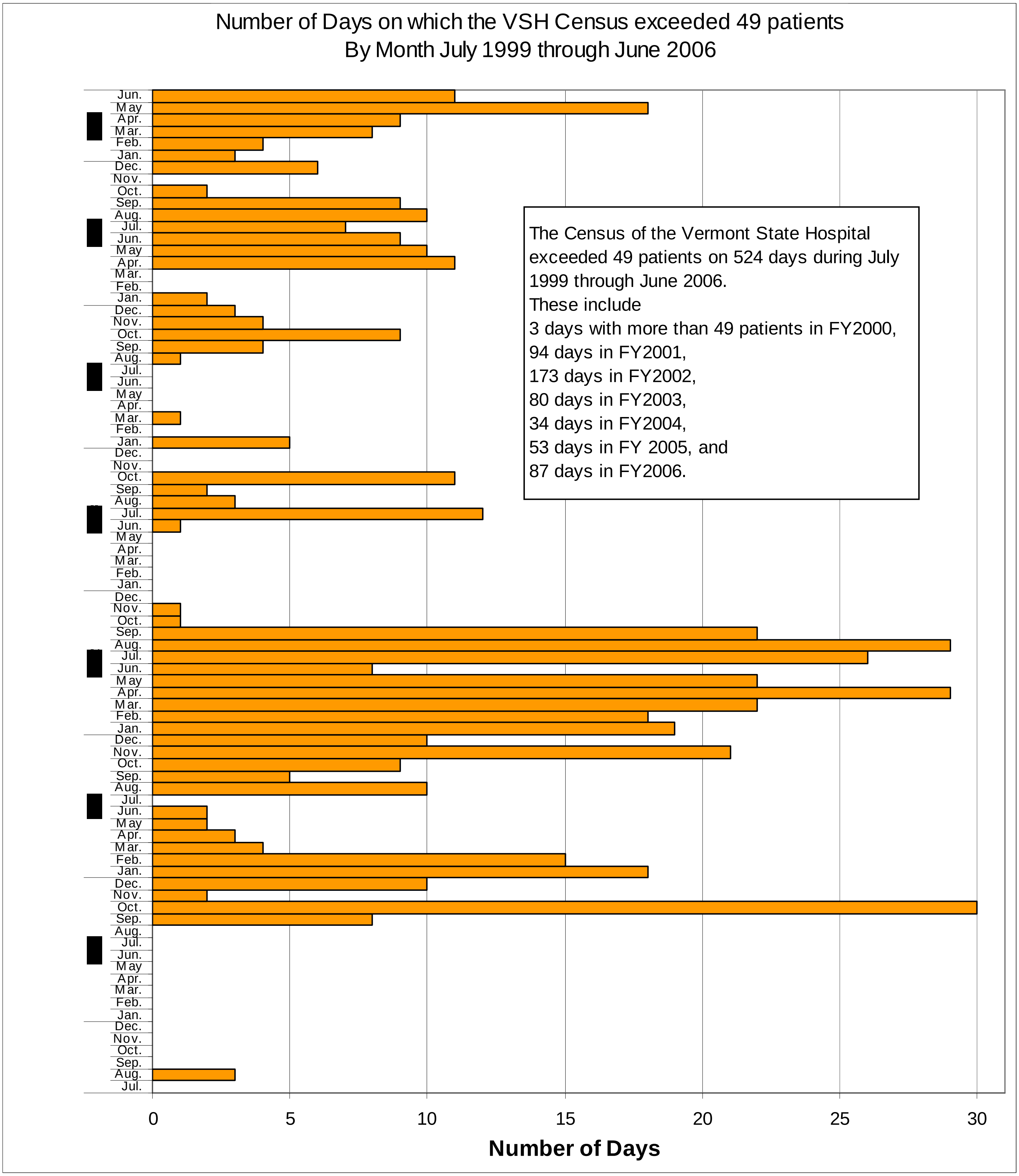
a. **Does it actually have beds, bedrooms and/or living accommodations for 54 individual patients to be served simultaneously?**

Yes. VSH can actually accommodate 54 patients. From our discussion with RRMC our understanding is that although Rutland is licensed for 19 beds it only actually uses up to 12 of these beds. The reason for this is that the physical lay-out at Rutland does not allow for appropriate programming for 19 beds.

How many times from July 2002 through June of 2006, by month, did VSH reach this maximum physical capacity?

See Graphs, “Number of Days in Which the VSH Census Exceeded 53 Patients By Month July 1999 Through June 2006”, and “Number of Days on Which VSH Census Exceeded 49 Patients by Month July 1999 Through June 2006”, below.


Number of Days on which the VSH Census exceeded 53 patients
By Month July 1999 through June 2006
The Census of the Vermont State Hospital exceeded 53 patients on 50 days during July 1999 through June 2006.
These include
0 days with more than 53 patients in FY2000,
5 days in FY2001,
26 days in FY2002,
19 days in FY2003,
0 days in FY2004, 2005, and 2006.
0
5
10
15
20
25
30
Number of Days


Number of Days on which the VSH Census exceeded 49 patients
By Month July 1999 through June 2006
The Census of the Vermont State Hospital exceeded 49 patients on 524 days during July 1999 through June 2006.
These include
3 days with more than 49 patients in FY2000,
94 days in FY2001,
173 days in FY2002,
80 days in FY2003,
34 days in FY2004,
53 days in FY 2005, and
87 days in FY2006.
0
5
10
15
20
25
30
Number of Days

137. The application makes references to patients at VSH as having the "highest acuity" among psychiatric inpatients.

a. **How is acuity defined clinically?**

The general meaning in Vermont when being used to refer to the severity level of either a patient being referred to a psychiatric inpatient unit, or to the condition of the ward or unit itself. In referencing a person, such issues as risk, responsiveness to treatments, collaboration with treatment, community and family supports are taken into account. A nationally recognized instrument, LOCUS, is commonly used to measure this meaning of acuity. When used in reference to a ward or unit, such issues as the numbers of patients with a risk of harm to self or others, the amount and complexity of nursing care needed and the impact on the ward milieu of very active or intrusive patients, whether dangerous or not, are taken into account.

b. **Is there a direct clinical relationship between acuity and the need for security?**

Frequently there is, since one of the indicators is risk of danger, though this is not the only or even a necessary part of the definition

c. **If so, please provide clinical substantiation.**

Occasionally people with a psychotic illness recently admitted to a hospital may have delusions of persecution or be in an excited manic state in which their usual, non-psychotic level of judgment is impaired and they can become violent. In this instance, sometimes it is possible to communicate with them and help them reason through their contemplated actions, at other times it is not possible, either due to the psychotic process or to the suddenness and unpredictability of the aggressive behaviors. Similarly, some people are profoundly depressed and intent on suicide. The treatments for depression typically take time to become effective and a safe, secure environment that can closely monitor the safety of such patients is needed.

d. **Among those patients generally described as "forensic" patients because they have been referred by the courts, is there consistently the same level of acuity? Please explain.**

Legal status is unrelated to clinical status. "Forensic" patients exhibit the entire spectrum of acuity that any other person with a mental illness can manifest, from mild to very severe symptoms. Having charges brought against one is unrelated to having symptoms of mental illness.

138. On page 18, the application states that designated hospitals can now accept forensic referrals.

a. **How many such referrals have been admitted to a designated hospital since January 1, 2006?**

See chart below.

Forensic Referrals:

Jan. 1 2006 - Sept 27, 2006

# to VSH from court:	50
# to DH from court:	6
Total	56
Not included in Total above:	
Transferred to DH from VSH:	5
Transferred to VSH from DH:	2
Transfers after admission:	7

b. **Does the Division expect this figure to increase? Why or why not?**

We do not have formal projections of the number of patients who could be served in designated hospitals. We hope that designated hospitals will take all clinically appropriate referrals.

c. **What percent of current forensic admissions per month at VSH might not be in need of the "specialized" level of care provided only there, and could be served in a designated hospital's inpatient unit?**

It is specifically because we believe that not all of these admissions are in need of the specialized level of care that we sought the statutory change. We do not have formal projections of the number of patients who could be served in a designated hospital's general inpatient unit.

d. **Has this projection (from c above) been taken into account in assessing the needed bed capacity for VSH services in the future? If so, how? If not, why not?**

We do not have formal projections of the number of patients who could be served in a designated hospital's general inpatient unit.

139. The application states (p.18) that a person is currently only admitted to VSH on an emergency exam if all four designated hospitals have been unable to accept the patient.

a. **Please identify the number of persons, per month, since January 1, 2004, who were admitted for an emergency examination at the first designated hospital contacted for admission, at the second referral, at the third referral, and not until the fourth referral.**

VDH cannot answer this question. We know why someone was refused an emergency examination at various designated hospitals, if the individual is admitted to VSH, but we do not track how many hospitals were tried before the individual came to VSH. Division policy requires that at least two designated hospitals are tried prior to VSH accepting the admission.

b. **Among those admitted at the third or fourth referral, please identify their home county and the distance that hospital was from their home county.**

We do not have the data to answer this question.

140. The application (page 18) states that Vermont has "an important opportunity to plan for replacement services that are voluntary," stating that some of the care currently delivered at VSH could probably be delivered voluntarily if other options were available.

a. **If the current inpatient care at VSH has a capacity of 54, and the replacement options proposed in this application include 50 beds (page 57), all of them ranging from secure "specialized" to high security "intensive care" beds, please explain in what aspect the Department has developed a proposal that creates *replacement* services that are voluntary.**

The replacement option for 50 inpatient beds is based in part on actuarial projections for 2016. The Community Residential and Secure Residential Programs are replacement services that are voluntary.

b. **Alternatively, in describing 18 "subacute" and six "secure residential" beds as being *"relocated from VSH"* (page 67), why would it not be considered that this proposal is actually seeking to increase the (remaining) capacity from 30 to 50?**

The language describing the relocated 32 – 50 bed increase reflects changes made as the plan evolved . These changes reflect the evolution of our planning process. The "relocation" language reflects an earlier stage of that process; the replacement option for 50 inpatient beds is based in part on actuarial projections for 2016.

c. **In what ways does the proposal support state law and policy to reduce coercion in the system?**

Creation of additional voluntary options necessarily reduces the level of coercion in the system.

141. The application notes that the "relative strength of the community services infrastructure directly impacts the use of psychiatric inpatient care," (p. 19) thus acknowledging that the scope of the Futures plan and implementation of it is integral to identifying the level of need for replacement inpatient beds. In what specific ways does the VDH expect to demonstrate in a future CON application that the system has maximized the ability to provide voluntary and community-based alternatives?

VDH is aware of no certain methodology to identify the "maximum ability" of a system to provide community, voluntary alternatives to hospitalization. According to state profile data developed by the National Association of State Mental Health program Directors, Vermont has one of the highest rates of per capita funding for community mental health services in the nation and one of the lowest rates nationally for state hospital use. We believe that the development of the community alternatives described in the Futures Plan will help Vermont to continue to maximize community care and minimize involuntary inpatient care.(See Attachment 32)

142. The application cites a need for specialized and intensive care beds higher than at the level Milliman cites under "full implementation" but the application states at page 59 that "The number of beds proposed for the inpatient psychiatric facilities that are the subject of this Conceptual CON Application rest on the assumption that the Futures plan will be fully implemented." Please explain this apparent discrepancy.

On page 59 we are quoting verbatim the HRAP which is referring to the Feb 05 Futures Plan. The differing numbers refer to different numbers produced at different stages of the planning process. The numbers have evolved. Our Application states we are seeking permission to plan for 50 psychiatric inpatient beds.

143. The application states on page 17 that there are three "forensic" categories for admission to VSH, each involving persons in need of inpatient care.

Regarding (a), (b) and (c): VSH works very hard to arrange discharges for people no longer in need of inpatient care. In some instances delayed access to the court docket may result in people in category 2 (p 17) staying longer. In rare instances a person in category 3 may stay longer. There are no individuals at VSH currently in category 3.

a. **Do any such individuals remain at VSH after they are no longer in need of inpatient care? If so, in which categories?**
b. **Who makes the decision to not discharge the individual from inpatient care?**

Discharge decisions for individuals in categories 2 and 3 are based on clinical assessment and judicial ruling.

c. **Does the VDH propose any changes in law, rule procedure or policy that would place more control with an inpatient facility regarding when its clinical services are needed in such cases?**

None planned currently.

144. For each of the three categories of forensic care, please provide data for the past ten years on the rate of growth or decrease in that category. Specifically note the rate of persons charged with a criminal act who are referred as inpatients for competency evaluations as compared to the increase or decrease of all persons charged with crimes; the rate of findings of not guilty by reason of insanity and rates and lengths of stay of resulting inpatient hospitalization; and the rate of incarceration in the population as compared to the rate of persons who are incarcerated and are referred for inpatient care. Please explain how the future needs for the incarcerated population will have been adequately assessed and addressed through the actions proposed by VDH.

See Table below, "Vermont State Hospital Forensic Admissions January 1997 – August 2006".

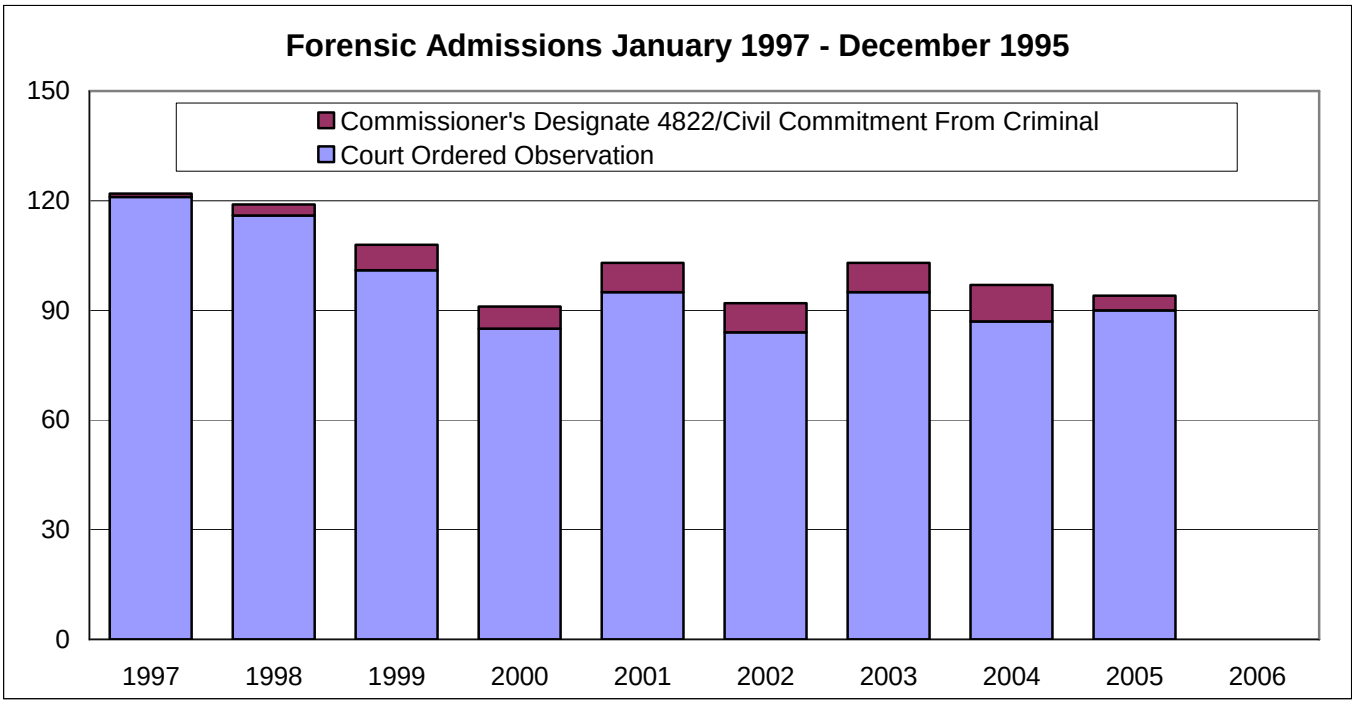
VDH does not track criminal charges for the general population so we cannot provide trend comparisons between referrals for inpatient competency evaluations and criminal charges for the general population. There have been no findings of "guilty by reason of insnity" in the last twenty years. VDH does not track the rate of incarceration in the population, nor do we track the rate at which incarcerated individuals are referred for inpatient care. Below is a table summarizing the number of admissions to Vermont State Hospital by month for the most recent 10-year period for both civil commitments from a criminal proceeding and for competency evaluations.

The Department of Corrections has been an active participant in Futures Project planning processes.

In addition, the actuarial study (Milliman, Appendix B of the August 17, 2006 CON Application) based its projections on inpatient utilization and trends for all Vermonters, including individuals who were incarcerated.

Vermont State Hospital Forensic Admissions
January 1997 - August 2006

Admission Year	Forsenic Type	Admission Month Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Yearly Total
1997	Court Ordered Observation	9	6	9	16	8	10	13	16	12	8	4	10	121
1997	Commissioner's Designate 4822	0	0	1	0	0	0	0	0	0	0	0	0	1
1998	Court Ordered Observation	7	11	14	6	12	10	11	10	8	8	9	10	116
1998	Commissioner's Designate 4822	0	0	0	0	0	0	2	0	1	0	0	0	3
1999	Court Ordered Observation	9	7	9	11	10	9	11	10	8	8	5	4	101
1999	Commissioner's Designate 4822	0	0	0	0	0	1	0	0	0	1	0	5	7
2000	Court Ordered Observation	6	4	4	7	5	5	7	13	12	5	7	10	85
2000	Commissioner's Designate 4822	0	0	0	1	0	0	0	1	1	0	1	2	6
2001	Court Ordered Observation	9	9	2	9	10	7	11	10	8	8	4	8	95
2001	Commissioner's Designate 4822	0	0	1	0	0	0	0	2	0	1	0	4	8
2002	Court Ordered Observation	3	9	5	11	5	6	10	8	8	6	10	3	84
2002	Commissioner's Designate 4822	0	0	0	1	1	0	1	0	1	1	3	0	8
2003	Court Ordered Observation	10	10	7	6	7	8	9	13	10	6	4	5	95
2003	Commissioner's Designate 4822	0	0	0	1	2	1	0	0	1	0	0	3	8
2004	Court Ordered Observation	9	7	10	5	8	9	7	11	6	4	7	4	87
2004	Commissioner's Designate 4822	0	0	1	0	2	1	0	0	0	1	3	2	10
2005	Court Ordered Observation	3	10	9	14	11	7	8	6	4	5	6	7	90
2005	Commissioner's Designate 4822	0	0	0	0	0	0	0	0	0	0	1	3	4
2006	Court Ordered Observation	6	2	5	7	6	7	2	7					42
2006	Commissioner's Designate 4822	0	0	1	0	1	0	2	1					5



145. Is the assumption on page 25 that patients currently in need of an "intensive" level of services and being served at VSH would require fewer emergency interventions such as restraint and seclusion if the physical facility were different? Please explain. Please include any citations to support such assumptions.

The assumption underlying the concepts of ICU and Specialized Care presented on p 24 and 25 of the application is that appropriate staffing and better architectural design will improve the environment of care.

146. How will the preferred options support the policy objectives of the Vermont Health State Plan to enhance integration of care "by physically locating inpatient mental health services with medical services" (page 28), if the preferred option that is developed is "off the campus" of Fletcher Allen Health Care?

The preferred option is "on campus" for the reason that it would provide more opportunity for integration of care via collocation with a tertiary hospital. Off campus sites will be evaluated based on their relative ability to provide for the desired clinical attributes of integration with tertiary hospital care.

147. Regarding Northeastern Vermont Regional Hospital (NVRH):

a. **Has the VDH explored further Northeastern Regional Hospital's possible interest in "developing a general psychiatric inpatient program as a way to better serve their community" (p. 37) as part of its directive to plan for replacement of services for VSH "within...a comprehensive continuum of care"? Please explain.**

Developing general psychiatric inpatient programs is beyond the scope of the Futures Project and this Application. This project focuses on creating two new levels of care: specialized and intensive.

148. **How are the access needs of Vermonters to inpatient mental health care from its service areas currently being met? Please provide data contrasting regional access needs, based upon inpatient hospitalization rates and number of inpatient psychiatric beds currently available, that would be met by 10 additional general psychiatric inpatient beds in Rutland versus 10 general psychiatric inpatient beds at Northeastern.**

This Futures Plan and this application is not designed to plan at the care level of general hospital psychiatric inpatient beds.

b. **What would be the impact of a 10 bed program at NVRH on the need for new beds at FAHC?**

It is not clear what the impact of additional general hospital beds would be for specialized and intensive beds. It is not thought that one replaces the need for the other.

148. Please provide the citations that define whether a "facility," as the term is used by the application in defining IMD determinations on page 38, means a specific building, cluster of buildings, or can include buildings that are on different campuses and serve different medical specialties; and similarly whether "within general hospitals" means inside a physical structure versus within a corporate structure.

The term "facility" as used in the IMD analysis is synonymous with "institution." The Federal law defines an "institution" as "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." 42 C.F.R. §435.1009

CMS has issued the following guidelines to assist in determining whether more than one component or facility constitutes an "institution" for purposes of an IMD analysis:

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

Similarly, whether a psychiatric unit is "within a general hospital" does not necessarily imply *physically* within. Again, separate components must be deemed an "institution" based on the criteria above before it can be determined whether the "institution" is an IMD.

149. Please provide copies of all documentations relied upon by VDH to reach its conclusions regarding the IMD exclusion.

VDH relied on the following "documentations" relied upon by VDH to reach its conclusions regarding the IMD exclusion:

1. Centers for Medicare and Medicaid Services, publication no. 45, <u>The State Medicaid Manual</u> (Rev. 65) at 4390.(Attachment 33)
2. VSH Futures Report: Institutions for Mental Disease (IMD), prepared by Paul Wallace-Brodeur, February 2004. (Attachment 33)

150. Please provide copies of all communications to or from VDH regarding the IMD exclusion, including but not limited to communications with the Centers for Medicare and Medicaid Services.

VDH did not communicate with the Centers for Medicare and Medicaid Services regarding the IMD exclusion. Attached is a policy directive from the then Health Care Finance Administration in 1998 on this issue (Attachment 33). Also, attached is email correspondence between the Office of Vermont Health Access (Paul Wallace-Brodeur) and Joanne Peterson of CMS regarding the phasing out of Vermont's previous waiver of the IMD exclusion under the 115B Vermont Health Access Plan (VHAP) waiver.(Attachment 7, Q 15)

151. Please provide copies of all documentations relied upon by VDH to reach its conclusions regarding "provider-based status" (pp. 39-40).

VDH relied on the following "documentations" to reach its conclusions regarding "provider-based status":

1. Centers for Medicare and Medicaid Services, publication no. 100-07, State Operations Manual, (Rev. 16, 01-10-06) Chapter 2, Sections 2004, 2020 – 2054 (Attachment 33)

152. Please provide copies of all communications to or from VDH regarding provider-based status, including but not limited to communications with the Centers for Medicare and Medicaid Services.

There are no communications to or from VDH regarding provider-based status.

153. What are the "limited exceptions" set out in regulation to the "35-mile radius" rule noted in the application at page 4?

Below, please find the text of 42 CFR §413.65(e)(3) relative to the so-called "35 mile radius" rule for provider-based status and the exceptions. *Please note that there appears to be a typo in the regulations where it refers to a §(e)(3)(iii) as no such section appears to exist.*

(3) *Location.* The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider, except when the requirements in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this section are met:
(i) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of this chapter) greater than 11.75 percent or is described in §412.106(c)(2) of this chapter implementing section 1886(e)(5)(F)(i)(II) of the Act and is—
(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or
(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).
(ii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—
(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;
(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or
(C) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(ii)(A) or paragraph (e)(3)(ii)(B) of this section because it was not in operation during all of the 12-month period described in paragraph (e)(3)(ii) of this section, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(ii) of this section, accounted for at least 75 percent of the patients served by the main provider.
(iv) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

154. Table 5 (p. 42) regarding the sources of funds for inpatient psychiatric care is helpful but to better understand the funding issues at VSH and compare them to those at each of "Vermont's community and tertiary care hospitals" (p. 41) please provide a matrix or chart illustrating the funding amounts and sources, from July 2000 though the present, including the following (at VSH, at each of "Vermont's community and tertiary care hospitals", and at Retreat Healthcare):

a. **percentage funding by Medicaid**
b. **percentage funding by other federal sources (explain)**
c. **percentage funding by other governmental sources (explain)**
d. **percentage funding by third party payers (explain)**
e. **percentage free care**
f. **percentage bad debt**
g. **percentage self pay**
h. **other (explain)**

Data is provided back to FY 2002. BISHCA's web site does not have data prior to FY 2002. At this point, data from Retreat Healthcare is not available. See charts below for data.

Vermont Community Hospitals
PAYER MIX STATISTICS
SOURCE: BISHCA's web site - VT Community Hospitals Financial & Statistical Profiles

FISCAL YEAR 2006 BUDGET

Provider	Medicare % of Gross Rev	Medicaid % of Gross Rev	Comm/self % of Gross Rev	Bad Debt %	Free Care %
Brattleboro Memorial Hospital	40%	12%	48%	2.5%	2.0%
Central Vermont Hospital	35%	13%	42%	2.3%	1.2%
Copley Hospital	33%	19%	49%	4.4%	1.6%
Fletcher Allen Health Care	25%	9%	31%	1.5%	1.5%
Gifford Memorial Hospital	35%	17%	48%	3.5%	1.5%
Grace Cottage Hospital	41%	9%	23%	0.6%	1.7%
Mount Ascutney Hospital	38%	14%	36%	2.1%	0.8%
North Country Hospital	36%	16%	32%	2.7%	0.7%
Northeastern VT Regional Hospital	37%	18%	38%	2.3%	2.4%
Northwestern Medical Center	35%	19%	45%	3.5%	1.2%
Porter Medical Center	33%	12%	42%	3.5%	0.9%
Rutland Regional Medical Center	48%	11%	41%	1.9%	1.0%
Southwestern Vermont Medical Center	47%	11%	42%	1.5%	1.5%
Springfield Hospital	44%	16%	41%	2.4%	2.4%
SYSTEM	32%	11%	36%	1.9%	1.4%
MEDIAN	36%	14%	41%	2.3%	1.5%

FISCAL YEAR 2005 PROJECTED

Provider	Medicare % of Gross Rev	Medicaid % of Gross Rev	Comm/self % of Gross Rev	Bad Debt %	Free Care %
Brattleboro Memorial Hospital	41%	12%	48%	2.2%	1.8%
Central Vermont Hospital	34%	13%	42%	2.2%	1.6%
Copley Hospital	33%	19%	49%	4.6%	1.4%
Fletcher Allen Health Care	25%	9%	31%	1.6%	1.5%
Gifford Memorial Hospital	36%	17%	47%	3.5%	1.4%
Grace Cottage Hospital	40%	9%	22%	0.6%	1.7%
Mount Ascutney Hospital	38%	16%	35%	1.6%	0.8%
North Country Hospital	36%	16%	32%	2.4%	0.6%
Northeastern VT Regional Hospital	38%	18%	38%	2.3%	2.1%
Northwestern Medical Center	36%	19%	45%	3.6%	1.2%
Porter Medical Center	34%	12%	42%	3.0%	0.8%
Rutland Regional Medical Center	47%	12%	41%	2.1%	1.0%
Southwestern Vermont Medical Center	47%	11%	42%	1.8%	1.2%
Springfield Hospital	44%	16%	39%	2.3%	2.6%
SYSTEM	32%	11%	36%	2.0%	1.4%
MEDIAN	37%	14%	41%	2.3%	1.4%

FISCAL YEAR 2004 ACTUAL

Provider	Medicare % of Gross Rev	Medicaid % of Gross Rev	Comm/self % of Gross Rev	Bad Debt %	Free Care %
Brattleboro Memorial Hospital	40%	12%	48%	3.1%	2.2%
Central Vermont Hospital	35%	13%	42%	2.6%	2.2%
Copley Hospital	32%	18%	50%	4.3%	1.0%
Fletcher Allen Health Care	26%	8%	30%	1.7%	1.8%
Gifford Memorial Hospital	35%	18%	46%	3.1%	1.1%
Grace Cottage Hospital	40%	9%	23%	0.5%	1.7%
Mount Ascutney Hospital	39%	13%	37%	2.5%	0.8%
North Country Hospital	35%	16%	30%	2.9%	0.9%
Northeastern VT Regional Hospital	37%	18%	40%	2.4%	0.9%
Northwestern Medical Center	35%	18%	47%	3.5%	1.2%
Porter Medical Center	33%	10%	44%	3.4%	0.3%
Rutland Regional Medical Center	48%	12%	40%	2.4%	0.6%
Southwestern Vermont Medical Center	47%	11%	42%	2.6%	1.0%
Springfield Hospital	43%	16%	40%	3.5%	2.8%
SYSTEM	32%	11%	36%	2.2%	1.5%
MEDIAN	36%	13%	41%	2.8%	1.0%

FISCAL YEAR 2003 ACTUAL

Provider	Medicare % of Gross Rev	Medicaid % of Gross Rev	Comm/self % of Gross Rev	Bad Debt %	Free Care %
Brattleboro Memorial Hospital	41%	11%	48%	2.7%	2.0%
Central Vermont Hospital	35%	12%	42%	2.5%	1.5%
Copley Hospital	30%	19%	50%	3.6%	1.1%
Fletcher Allen Health Care	27%	8%	31%	1.4%	1.5%
Gifford Memorial Hospital	37%	17%	46%	7.1%	1.0%
Grace Cottage Hospital	41%	9%	25%	0.8%	1.9%
Mount Ascutney Hospital	42%	14%	33%	1.7%	0.9%
North Country Hospital	39%	14%	28%	2.1%	0.7%
Northeastern VT Regional Hospital	38%	17%	39%	2.4%	0.5%
Northwestern Medical Center	36%	17%	47%	4.1%	1.3%
Porter Medical Center	33%	14%	40%	3.3%	0.6%
Rutland Regional Medical Center	48%	11%	41%	2.6%	0.7%
Southwestern Vermont Medical Center	45%	11%	44%	1.9%	1.1%
Springfield Hospital	45%	17%	39%	2.5%	2.4%
SYSTEM	33%	11%	36%	2.1%	1.3%
MEDIAN	39%	14%	41%	2.5%	1.1%

FISCAL YEAR 2002 ACTUAL

Provider	Medicare % of Gross Rev	Medicaid % of Gross Rev	Comm/self % of Gross Rev	Bad Debt %	Free Care %
Brattleboro Memorial Hospital	40%	11%	49%	2.8%	2.3%
Central Vermont Hospital	36%	12%	41%	2.9%	1.3%
Copley Hospital	35%	18%	48%	3.7%	1.3%
Fletcher Allen Health Care	27%	8%	32%	1.8%	1.8%
Gifford Memorial Hospital	38%	15%	47%	3.9%	1.2%
Grace Cottage Hospital	42%	8%	25%	0.8%	1.2%
Mount Ascutney Hospital	41%	16%	31%	1.1%	0.9%
North Country Hospital	36%	16%	29%	1.6%	0.0%
Northeastern VT Regional Hospital	37%	17%	36%	2.5%	0.5%
Northwestern Medical Center	36%	17%	47%	3.2%	1.1%
Porter Medical Center	36%	11%	40%	2.8%	0.4%
Rutland Regional Medical Center	45%	13%	42%	2.1%	0.8%
Southwestern Vermont Medical Center	46%	11%	43%	1.6%	0.7%
Springfield Hospital	42%	16%	42%	2.3%	2.3%
SYSTEM	33%	11%	37%	2.1%	1.4%
MEDIAN	38%	14%	42%	2.4%	1.1%

Vermont State Hospital - Payer Mix % Funding Source of Total Funding - Source: VISION & VSH Data					
	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
% Medicaid	62.0%	56.4%	33.9%	20.4%	0.0%
% Other Federal	7.1%	6.1%	2.2%	2.9%	0.0%
% General Fund	28.9%	34.5%	60.5%	75.6%	96.1%
% Other State	2.0%	3.0%	3.4%	1.2%	3.9%
% Third Party	0.0%	0.0%	0.0%	0.0%	0.0%

1**55. What has VDH done, or does it plan to do, to explore other options, including but not limited to:**

a. **upgrading the existing facility**

When the Vermont State Hospital first lost its certification, the Department of Buildings and General Services in collaboration with the Vermont Department of Health, surveyed the existing facilities and proceeded with remediation of potential ligature points in patient rooms and toilet rooms. The following year, funds were appropriated to perform additional work. The work completed included improvements to seclusion rooms, porch repairs, enclosure of the exit stair tower, improvements to the heating and ventilating systems, installation of air conditioning, provisions for shelters and ice protection in the recreation yard, provisions for quiet rooms and additional safety work. The FY '07 Capital Bill appropriated additional funds to continue with safety upgrades in response to an independent survey of the facility. This survey identified a number of safety issues, patient management issues, and environmental enhancements. The safety work is complete, and we are proceeding with the patient management and environmental enhancement issues. It is planned for a safety committee to be established to continue the pursuit of safety needs within the facility.

b. **building a new facility on the Waterbury campus**
c. **purchasing an existing facility**
d. **building on available land at or near other hospitals**

With regard to (b), (c), and (d): As stated in the CON Application, we have begun exploring building a stand alone facility. This option is not site specific. VDH regards upgrading the existing facility or building a new facility on the Waterbury campus as options that are not viable. Investing in upgrades of the existing facility at Waterbury in an isolated building or building a new facility there does not make sense in terms of the objective of co-location of clinical services. Purchasing an existing facility or building on land at or near other hospitals is not precluded by this CON Application. This would be further explored in Phase II.

156. What implications would this proposal have on the Medicare cost reports of FAHC, RRMC, and the Retreat?

This will be addressed in Phase II.

157. Does the State have an agreement(s), either in principle or in writing, with FAHC, RRMC and/or the Retreat in furtherance of the project? If so, please submit documentation.

There are no agreements, with FAHC, RRMC and/or the Retreat in furtherance of the project.

158. Please provide specific information on the decisions made in other states with respect to closing state hospital programs. Have any other states given up complete control of all their inpatient facilities?

We have conducted preliminary and informal discussions; very few other states have only one state hospital.

159. Has VDH consulted with experts on the provision of inpatient psychiatric care? If so, please submit their reports and recommendations.

Yes, on the topic of re-certification. Consultation reports (Attachment 34) were provided by:

- Fletcher Allen Health Care Report to the Vermont Division of Mental Health October 31, 2005
- Andrew Pomerantz, MD, Chair, VSH Review Committee, Memorandum to Paul Jarris, MD, MBA, Commissioner, Vermont Department of Health, VSH Review Committee Recommendations

160. Is the VDH aware of concurrent interest at one or more Vermont hospital(s) to develop new general inpatient psychiatric bed units? Please explain.

We are not aware of such interest at this time.